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Practical Applications for Quality Improvement in Myelofibrosis Management: A Video Brief on Lessons Learned

Announcer:
Welcome to ReachMD. This activity, titled "Practical Applications for Quality Improvement in Myelofibrosis Management: A Video Brief on Lessons Learned" is provided by AXIS Medical Education.

Dr. Kim:
Thank you for joining us as we discuss quality improvement in myelofibrosis. We are going to share with you the experiences of two cancer centers that worked with us on a Quality Improvement Program as they examine ways that they can improve care for patients with both primary as well as secondary myelofibrosis.

Both cancer centers began by assessing how often they are performing molecular testing in their patients with myelofibrosis and that allowed them to establish a baseline performance and see how they may be able to make improvements in that area.

The other key aspect of care that they focused on was around the use of a systematic symptom burden assessment tool, something like the MPN-10. Were they using such a tool to both quantify as well as document symptom scores, and how are they incorporating that to personalize as well as tailor treatments for patients with primary and secondary myelofibrosis.

A third area that they looked at was around the use of prognostic and risk stratification tools. Were they actually using these and documenting risk scores, and once again tailoring treatment options based on this information.

As care teams gathered, they assessed their current practice behaviors, and then they also were asked to evaluate how often patients with both primary and secondary myelofibrosis were being treated with various JAK inhibitors. Given that the landscape of JAK inhibitor therapy has rapidly changed in the last several years.

The cancer clinicians participating in this quality improvement program receive continuing education on ways that they can incorporate the use of JAK inhibitors to personalize treatment plans for patients with myelofibrosis. Using this information, they were then able to engage patients in shared decision-making conversations, and adjust treatment plans and personalized care for patients based on their risk factors as well as the types of symptoms that they were experiencing.

So as we worked with these cancer centers, we found that there were several key opportunities for improvement.

First, let's talk about molecular testing. We found that in almost every case, molecular testing was ordered and performed for patients with myelofibrosis being diagnosed and worked up in the outpatient setting. However, for those who may have had their initial diagnosis in the hospitalized inpatient setting, those tests were either delayed or not ordered. Part of that was due to breakdowns in communication when the patient is hospitalized with the oncology clinicians working with the hospitalists and the pathology groups.

And then the other issue has to do with the fact that the assumption is that the patient is going to receive ongoing follow up once the patient gets discharged and sometimes that follow up doesn't occur in a timely fashion.

Another key topic that we addressed was regarding the use of the structured symptom assessment tools. Were they using something like the MPN-10 to assess, document, but also quantify the severity of symptoms, and then how are they using that and incorporating that into treatment plans?

We found that in many cases, oncology clinicians were not in the habit of incorporating such structured tools and hence this provided an opportunity for improvement.

The MPN-10 is a structured symptom assessment tool that allows patients to provide a rating scale from a zero all the way up to a 10 in areas such as fatigue, early satiety, abdominal discomfort, levels of inactivity, problems with concentration, night sweats, itching or pruritus, bone pain, the presence of a fever, or unintended weight loss.

By quantifying symptoms in each of these domains, clinicians were able to tailor and adjust treatment plans to ensure that patients were experiencing the highest level of quality of life possible.

Regarding the topic of prognostic risk scoring, we found that most oncology clinicians were not documenting a formal prognostic risk score. They were not calculating the risk, they were not incorporating that into the treatment plan, and therefore this also provided an opportunity for potential process and quality improvement in terms of how care is delivered for patients with myelofibrosis.

We found that most patients with myelofibrosis are initially treated with hydroxyurea. And while clinicians were aware of JAK inhibitor therapy, some felt reluctant or hesitant to start JAK inhibitors because they felt that this would worsen the patient's anemia. Clinicians had almost no experience using second-line JAK inhibitors in these two cancer centers that we worked with.

Clinicians also found that it was especially challenging to manage the anemia in patients with myelofibrosis and therefore it was difficult to customize treatment plans that would optimize quality of life for these patients.

So working with these two cancer centers, we summarized that symptom burden and prognostic scoring were areas where the clinicians could do a better job using structure tools and formal assessments and documenting this information to ensure that treatment plans reflect customized and tailored approaches for patients.

We also found that clinicians had opportunities to learn more about treatment sequencing with JAK inhibitors so that they can understand both the clinical science and the evidence to support how and when these inhibitors should be used in patients with myelofibrosis.

Clinicians reported that they had moderate knowledge about managing different types of cytopenias associated with myelofibrosis and as a result, the continuing education activities focused on these specific topics as well.

So let's walk through how these cancer centers developed problem statements as well as aim statements that allow them now to implement quality improvement methods and improve care for patients with myelofibrosis.

In this first example, suppose that a cancer center reviews their data and realizes that the set proportion of patients with myelofibrosis is not receiving timely molecular testing at the time of diagnosis. They would then dive into a root cause analysis and really try to understand "what are the reasons why?" testing the suboptimal. Is it that we are forgetting to order the test? Is it due to forgetfulness? Is it due to a lack of communication? Perhaps someone plans to order the test and they verbally communicate it, but then they forget to write it down.

Perhaps it also has to do with accountability. Who is ultimately responsible for ordering the test and managing the patient? Is it one person? Is it a team of clinicians? So there may be a number of reasons why testing either doesn't get ordered or testing gets delayed.

Once that root cause, Once all the root causes are explored, then the team can develop some plans to make improvements and they can develop an AIM statement to say, "Well, we aim to improve testing rates by 15% by 20% and we plan to do this by such and such a date."

So you want to quantify how much you aim to improve and you also want to set an end date. A realistic but also a feasible end date in mind.

Understanding the root causes will also allow the team to develop feasible and practical solutions that will then allow them to make those improvements.

So as an example, if they realize that perhaps we are forgetting to simply order the right tests at the time of diagnosis, then the clinicians can develop, for example, either a care pathway or a templated note in their electronic record, so that anytime a new patient with myelofibrosis is being introduced into the practice, automatically right there, the treatment plan populates with, "Here are the tests to make sure that you order at the time of diagnosis." This information will help to tailor treatment plans as well as to assess prognosis.

So a simple solution such as a templated care plan, a pathway or some kind of a note or reminder in the electronic record can then help clinicians make sure that the tests are being ordered and that the right tests are being ordered as patients are diagnosed.

Another example of a potential intervention would be to have either nurses or advanced practice providers who are part of that care team helping to manage and ensure that the the right diagnostic tests are ordered at the time when patients are initially seen.

So for example, an oncology nurse or a navigator might review the chart and say, oh, you have a new patient and here is the the diagnosis, it's primary myelofibrosis. Let's make sure that we order these tests essentially using a checklist to make sure that the right tests are being ordered. And that way it really becomes a team-based approach with different people managing different aspects of that initial diagnostic process, and people like nurses or advanced practice providers using a checklist to ensure that the correct tests are being ordered.

Let's now look at the example of assessing patient symptoms and documenting those symptom scores and using that information to tailor an improvement care for patients with myelofibrosis.

Suppose that after you perform your baseline assessment, you realize that none of the patients who have myelofibrosis have a documented symptom score.

Now, this also provides an opportunity for a root cause analysis and you can ask clinicians why don't we do this? Why aren't we doing this? Is it simply that we are not in the habit of doing it? Perhaps clinicians don't know how to use a tool like an MPN-10, or how they might use that information to tailor the treatment plan.

It allows the care team to come together and assess, “How do we want to make an improvement in this area? Do we think that it's realistic and feasible to use something like an MPN every time a patient with myelofibrosis is seen in the practice and to document that score into the chart?” If we feel that that is feasible, then it would be real, realistic and reasonable to say that, hey, we want to improve the use of a structured symptom assessment tool, such as an MPN-10. We want to do this not only at the initial visit for every patient with myelofibrosis, but also at the subsequent visits to ensure that we're tracking how their symptoms are either progressing or are being alleviated with these therapies.

One easy and feasible way to do this would be to print out a tool like the MPN-10, have a nurse or an advanced practice provider review those questions with the patient at the visit, and either scan that form into the chart or to have that form digitized so that that information can be entered right into the electronic health record.

From a workflow perspective, the use of a paper form versus an electronic form has to be considered based on the use of your electronic records as well as whether or not patients or clinicians are going to be the ones filling out this information.

Some cancer centers may even find that it makes sense to allow the patient to fill out the form and once again, whether the patient is filling it out using a paper form or using some form of an electronic version is really going to be dependent on the practice’s capacity and capability, but also the willingness of the patient.

Now, once you capture information like the MPN-10 into the chart, not only can you track how the symptoms may be progressing and changing overtime, but you can also quantify the effectiveness of different therapies such as the use of a JAK inhibitor. And it may remind clinicians to look at: What is the dose that the patient is receiving? Is the patient receiving the optimal dose, or perhaps it might make sense now to consider a different therapy because maybe the current therapy is not working in an optimal way for this particular patient?

So when it came to symptom assessment and documentation, we found that cancer centers agreed that it was important to do. They found that they can involve their nurses, their advanced practice providers or navigators if they have them, to capture this information and enter it into the chart.

We found that some practices preferred using paper forms and scanning them, while others prefer to enter the form the information directly into their electronic record using some kind of a electronic templated form.

And all of those methods really vary based on both your practice’s capacity as well as the use of your electronic health record and its your ability to customize and incorporate such built-in electronic templates.

Clinicians at the cancer centers also reviewed the importance of using prognostic risk scoring tools, and documenting this information to tailor treatment plans for patients with myelofibrosis. Similar to the use of structured patient assessment and symptom scores, these clinicians decided that they would calculate the risk score either separately or directly in the electronic record and then incorporate that information into the chart to assess not only the prognosis, but also to see how they may want to tailor and adjust therapies for patients with myelofibrosis.

The plan, do, study, act, or PDSA cycle, is a commonly employed quality improvement methodology that's simple and structured.

And using the example of symptom assessment in patients with myelofibrosis, we can walk through how a team of clinicians may incorporate and utilize the PDSA cycles to improve symptom assessment as well as documentation.

So you start by planning your improvement and in order to plan, you have to ask what is it that we are trying to accomplish and how will we know if we've actually made a change and if that change has really led to an improvement in care.

So you work with your team to assess how you're currently assessing symptoms, and you may find, for example, that 30% of your patients with myelofibrosis have no documented or formal symptom assessment in the chart. This now provides you with an opportunity to make an improvement. So you would draft your aim statement where you aim to improve by such percent by such a date.

We've talked about the importance of a root cause analysis so that you understand why things are happening, that they the way that they are happening now and it offers you an opportunity to explore ways that you can apply mini experiments, small little interventions to make those incremental improvements.

So you would describe the problem and then you're going to identify some possible interventions. One example that we spoke about earlier was to say that you're going to print and use paper MPN-10 forms. You're going to have the nursing staff fill them out. You will have that form now scanned in the electronic record where the oncologist will review that information and tailor treatment plans according to the symptoms score.

So you've now developed a new workflow and you can document how you do with this new intervention. You've identified who is going to print out the form, who's going to fill it out, who's going to scan it, and how the oncologist is going to use that information. So you can map that all out and you can now implement this into the workflow, and begin to see what impact it has.

So suppose you meet with your team and you implement this new workflow and you decide after a month you are now going to review and see how well did it work. Did the nurses remember to print and use the MPN-10 form? Did they remember to scan and upload the information into the chart that the oncologists look at that information and tailor treatment plans.

Hence the PDSA cycle is a repetitive cycle where you continuously assess the impact of your improvements. You study the impact and then you're going to act on it. If you find that this is working really well and it's sustainable, you can continue this process and perhaps even improve in other areas, such as prognostic scoring, and other aspects of treatment.

If, on the other hand, you find that, well, some of the nurses are doing it but others are not. Or perhaps they're filling it out, but they forget to scan it. Or maybe they're scanning it, but the oncologists are not looking at the information.

It allows you now to conduct a new PDSA cycle and tackle what that issue is, or that problem might be so that you can continuously refine and make improvements that ultimately are sustainable but meaningful.

You have to make sure that the improvements are not just busy work: that the clinicians are really incorporating this information to tailor and improve care for patients and that it's leading to better symptom assessment and management as well as improve quality of life for your patients with myelofibrosis.

The cancer centers working with us on this quality improvement program received coaching and guidance on how to perform the baseline assessment as well as some ideas on how they may be able to improve care for patients with myelofibrosis. They received continued education on ways to tailor and improve treatment plans for patients, as well as incorporate JAK inhibitors, but also employ team based approaches to care coordination, and utilize shared decision-making to ensure that treatments are personalized for patients with myelofibrosis.

Here's what the shared decision-making guide look like for this program. It starts by reminding the clinicians about the 6E's to shared decision-making. The first E is to Ensure that you see and treat the patient as an individual and not as a disease.

The next E is to Elevate the patient centric experience and improve satisfaction with care.

Next we have Enable a long term personal connection with your patient.

Then Establish co-created treatment plans that align medical evidence with patient preferences to foster adherence and optimize outcomes.

The next E is for Elicit patient and caregiver preferences, values and goals for therapy,

And the final E is to Evaluate the risks and benefits and costs of treatment so that they are aligned with patient's expectations.

By incorporating these E's into the shared decision-making process and into those conversations with patients with myelofibrosis, oncologists were able to customize treatment plans, adjust drug doses, track symptom progression and ultimately provide the highest level of quality. the highest quality of care for patients with myelofibrosis as they continued their follow up with the oncologists.

As a result of employing quality improvement methods, but also incorporating continuing education, these cancer centers that

participated in this quality improvement program were able to improve molecular testing in patients with myelofibrosis by roughly 7%.

They also were able to incorporate a symptom assessment score using something like the MPN-10 and they were able to do this for over 90% of their patients with myelofibrosis.

Clinicians at the cancer centers also made improvements in how they were documenting and incorporating prognostic risk into the treatment planning process for patients with myelofibrosis. They did this either by printing out these forms and calculating risks separately, filling out a web-based form, or incorporating it right into the patients chart.

Using this information, they were then able to tailor treatment plans accordingly for patients who have both primary as well as secondary myelofibrosis.

Through continuing education as well as the use of quality improvement methods, the oncologists at these cancer centers were able to incorporate the use of JAK inhibitors when treating patients with primary as well as secondary myelofibrosis. They were better equipped because they had these symptoms scoring information on the chart and they had quantified that and they could track it over time.

They could know whether a initial JAK inhibitor was working or if they should consider switching to a different JAK inhibitor. They also had the prognostic risk information in the chart to tailor treatment plans.

All of this enabled the clinicians to engage patients in shared decision-making conversations to be able to tailor treatments based on different patient factors risk factors, but also the goals of treatment for the patients.

This led to more patients being treated with JAK inhibitors and it also enabled the oncologists to use second line and newer JAK inhibitors in the treatment of patients with both primary as well as secondary myelofibrosis.

So in summary, we've reviewed how clinicians can improve care for patients with myelofibrosis by ensuring that molecular testing is occurring at the time of diagnosis by ensuring that they are assessing, quantifying, and documenting symptom scores, and using that information to tailor treatment plans; by assessing prognostic risk and incorporating that information into their treatment plans; and by engaging patients in shared decision-making conversations to ensure that treatment plans align with patient preferences and the goals of treatment.

This QI program also emphasized the importance of team-based care, incorporating and involving members of the care team, such as your nurses, your advanced practice providers, pharmacists, and others in different aspects of the process.

To ensure that proper follow up is occurring for patients who are on these different therapies so that you can either adjust doses or consider switching to a different therapy if the patient is not responding optimally to what you have prescribed.

This program emphasized the use of continuing education as well as quality proven methods and involving everyone on the care team with the shared vision and goal of improving care for patients with myelofibrosis.

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