MICHIGAN MEDICINE

Hematology & Oncology - Clinical Quality Overview

Division Clinical Units and Leads	Quality Committees and Roles
Division Chief: Pavan Reddy Quality Council Representatives: David Smith, Alice Cusick Division Administrator: Dorothy Schroeder 8A UH MPLAN lead: Alice Cusick 7 C&W MPLAN lead: John Magenau Adult BMT & Infusion ACUs: Dale Bixby	• CC Patient Safety / QI Committee Meeting o Dale Bixby • CMS Oncology Care Model (Application underway) o Al Quiery
Highest Volume Conditions	**Division Specific Specialty Conditions**
1. Breast Cancer 2. Urothelial Cancer 3. Colorectal Cancer 4. Prostate Cancer	1. Urothelial, Testis and Prostate Cancers 2. Breast Cancer 3. Head and Neck Cancers 4. Acute Leukemias
Measurement – Peer Review Metrics	**Measurement – Registries and Other Data**
<u>Rate-Based Indicators</u> • CC Patient Safety / QI Committee Meeting <u>Case-Based Indicators</u> • Sentinel event reviews • CC Patient Safety / QI Committee Meeting	<u>Quality Analytics</u> • ICU transfers • Death in hospital • Readmissions within 30 days
Choosing Wisely – National Standards	**Quality Improvement Priorities**
Oncology 1. Don't use cancer-directed therapy for solid tumor patients with the following characteristics: low performance status (3 or 4), no benefit from prior evidence-based interventions, not eligible for a clinical trial, and no strong evidence supporting the clinical value of further anti-cancer treatment. 2. Don't perform PET, CT, and radionuclide bone scans in the staging of early prostate cancer at low risk for metastasis. 3. Don't perform PET, CT, and radionuclide bone scans in the staging of early breast cancer at low risk for metastasis. 4. Don't perform surveillance testing (biomarkers) or imaging (PET, CT, and radionuclide bone scans) for asymptomatic individuals who have been treated for breast cancer with curative intent. 5. Don't use white cell stimulating factors for primary prevention of febrile neutropenia for patients with less than 20 percent risk for this complication. 6. Don't give patients starting on a chemotherapy regimen that has a low or moderate risk of causing nausea and vomiting antiemetic drugs intended for use with a regimen that has a high risk of causing nausea and vomiting. 7. Don't use combination chemotherapy (multiple drugs) instead of chemotherapy with one drug when treating an individual for metastatic breast cancer unless the patient needs a rapid response to relieve tumor-related symptoms. 8. Avoid using PET or PET-CT scanning as part of routine follow-up care to monitor for a cancer recurrence in asymptomatic patients who have finished initial treatment to eliminate the cancer unless there is high-level evidence that such imaging will change the outcome.	1. Discharge Planning for MHE/MON Services o *Alice Cusick* 2. Hospitalist and Oncologist Communication Project o *Rafina Khateeb, D'Anna Saul, David Smith* 3. Acute Leukemia Dashboard Development o *Alice Cusick, Dale Bixby* 4. ED and HemOnc Collaboration for Patient Pathway Opportunities o *David Smith, Dave Somand* 5. Preventing unnecessary hospitalizations

9. Don't perform PSA testing for prostate cancer screening in men with no symptoms of the disease when they are expected to live less than 10 years. 10. Don't use a targeted therapy intended for use against a specific genetic aberration unless a patient's tumor cells have a specific biomarker that predicts an effective response to the targeted therapy. **Hematology** 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). 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). 3. Don't use inferior vena cava (IVC) filters routinely in patients with acute VTE. 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). 5. Limit surveillance computed tomography (CT) scans in asymptomatic patients following curative-intent treatment for aggressive lymphoma. 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. 7. Don't routinely transfuse patients with sickle cell disease (SCD) for chronic anemia or uncomplicated pain crisis without an appropriate clinical indication 8. Don't perform baseline or routine surveillance computed tomography (CT) scans in patients with asymptomatic, early-stage chronic lymphocytic leukemia (CLL). 9. Don't test or treat for suspected heparin-induced thrombocytopenia (HIT) in patients with a low pre-test probability of HIT. 10. Don't treat patients with immune thrombocytopenic purpura (ITP) in the absence of bleeding or a very low platelet count.	