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# A Physician's Perspective on Quality Initiatives for Patients With Myeloproliferative Neoplasms (MPNs)

*"Quality care has become an increasing focus in oncology the last few years. When there is a widely agreed upon objective for a patient, there should be a process in place to meet that objective."*

Oncology practices across the country are recognizing the importance of developing and continually improving quality care. The goal of quality initiatives is to improve processes that help enhance patient outcomes while also increasing practice efficiencies. The clinical management of patients with myeloproliferative neoplasms (MPNs) continues to present challenges for hematologists and oncologists despite the existence of well-established clinical guidelines. As such, they represent a population that may benefit from disease-specific quality programs.

## We explore implementing quality care initiatives to achieve a positive impact on our practice

When we enhance outcomes, our patients talk about their success stories. This focus on quality, in turn, helps us in our goal to be recognized as a center of excellence in our community.

*"As part of an integrated practice, processes that you put in place should meet the standard of care and provide excellent care for the patient...this way, there's a better chance that quality care actually happens."*

Implementing quality initiatives for certain cancer types may also help our practice achieve Quality Oncology Practice Initiative (QOPI®) certification. The American Society of Clinical Oncology QOPI® Certification Program recognizes hematology/oncology practices that are committed to delivering the highest quality of cancer care.

## Regular symptom assessment should be a key component of a quality initiative for patients with MPNs

MPNs have been associated with a complicated symptom profile resulting in reductions in quality of life, functional status, and activities of daily living.<sup>1-3</sup> The symptoms of patients with myelofibrosis (MF), polycythemia vera (PV), and essential thrombocythemia (ET) vary within and between each MPN subtype but often include fatigue, pruritus, and night sweats, as well as symptoms from splenomegaly. MPN-related symptoms may persist even in patients receiving active therapy.<sup>4</sup> Proactive symptom assessment at baseline as part of the intake process and regularly during treatment can be incorporated into an MPN quality initiative.<sup>5</sup>

In PV, maintaining hematocrit control is a key therapeutic goal.<sup>6</sup> I also monitor white blood cell (WBC) count because elevated WBC count  $>11 \times 10^9/L$  is associated with an increased risk of thrombosis.<sup>7</sup> However, treating to goal is not just about monitoring blood counts. It's easy to think a patient with PV is doing well when their hematocrit is at goal, which for me is less than 45%, but when their total symptom score is higher than normal, which for me is an MPN-10 score  $\geq 20$ , a worst-individual item score  $>5$ , or a combination of both, and trending upwards over time, then their symptom burden may be high. This may suggest poor disease control and, perhaps, the need to take a closer look at the management approach for the patient.

The Myeloproliferative Neoplasm-Symptom Assessment Form Total Symptom Score (MPN-SAF TSS; commonly known as the MPN-10),<sup>1</sup> which can be downloaded at [mpnconnect.com](http://mpnconnect.com), helps me keep track of changes in patient symptom burden over time. The 10 questions on this form query the most

***“My perspective on PV changed when one of my patients told me quite directly to sit down and listen to her. Her struggles caused me to look more closely at symptom burden in all of my patients with PV. As a result, I ask all my patients with MPNs to regularly fill out a symptom assessment form, which I review during office visits and document in their electronic medical record.”***

representative and pertinent MPN-related symptoms to assess over time, including fatigue and other cytokine-related symptoms, hyperviscosity or vascular symptoms, and spleen-related symptoms.<sup>1</sup> Patient symptom scores are entered into the patient’s chart, which is regularly monitored by me and members of my nursing staff, who compare the patient’s total symptom score to his/her last visit and advise me of changes. Additional resources to help clinicians with the management of patients with MPNs can also be found on this website.

Many patients with MPNs do not recognize common symptoms as being related to their disease. For example, having problems with concentration may be caused by their disease, but it would likely not have been mentioned by a patient unless prompted by the MPN-10 Symptom Assessment Form.<sup>3</sup> Use of this form with patients with PV is particularly important because the signs of progression in PV can be subtle. Monitoring symptoms can help me recognize disease progression or when a patient with PV may be transitioning to MF or leukemia. I also monitor WBC and platelet counts and evaluate spleen size by palpation or imaging every 3 to 6 months to help me to determine if their treatment plan is working.

### **Practical insights for implementing a quality initiative for patients with MPNs**

At my practice, all laboratory values and information taken from patient interactions are entered into our electronic medical records (EMR) system and are regularly monitored by a collaborative team of physician assistants, nurses, nurse practitioners, and pharmacists. My phlebotomy orders are also recorded. However, we are still scanning the symptom assessment form into patient records, which isn’t ideal. To help improve efficiency, we are trying to build an electronic symptom assessment form into our EMR system that would allow us to longitudinally track patient symptoms over time.

We are also considering automation of the EMR system to alert me and other members of my staff when laboratory values are out of range or when a patient with PV, for example, has required frequent phlebotomies to control hematocrit, including those that patients report as having occurred while in the care of others.

Currently in our oncology practice, pharmacists play an important role in dosing decisions. Physicians and pharmacists collaborate before a medication is dispensed to a patient. Our pharmacy team has also played an instrumental role in the adoption of the medically integrated dispensing model in our practice. With a medically-integrated pharmacy, I am able to dispense oral drugs directly to patients, which allows for real-time care and helps to facilitate the implementation of quality initiatives for our patients with MPNs. Dispensing directly to patients also helps our staff save time and be more efficient.

Pharmacists can play a more active role in tracking blood levels, such as hematocrit and WBC count over time for patients with PV taking hydroxyurea. They have the ability to leave a note for clinicians, which would be a nice complement to helping us ensure quality care.

### **Summary Recommendations**

-  Encourage all patients with MPNs to complete a symptom assessment form on a regular basis
-  Employ a team approach to the implementation of quality care initiatives
-  Monitor patient symptoms as closely as you monitor lab values because a worsening of symptom burden could be a sign of disease progression

In summary, we encourage our patients with MPNs to complete the MPN-10 symptom assessment form on a regular basis. We have also found that it’s important to monitor patient symptoms as closely as you monitor lab values because worsening symptoms could be a sign of disease progression. At the end of the day, it truly takes a team approach to deliver quality care on a consistent basis. Ongoing monitoring of patients with MPNs is a critical component of caring for these people and the physician, nursing staff, and pharmacy team all play a role in delivering quality. More information and resources on implementing a quality initiative in your practice can be found at [mpnquality.com](http://mpnquality.com).

**References:** 1. Emanuel RM, Dueck AC, Geyer HL, et al. *J Clin Oncol*. 2012;30(33):4098-4103. 2. Scherber R, Dueck AC, Johansson P, et al. *Blood*. 2011;118(2):401-408. 3. Mesa R, Miller CB, Thyne M, et al. *BMC Cancer*. 2016;16:167. 4. Geyer H, Mesa RA. *Curr Hematol Malig Rep*. 2017;12(5):381-388. 5. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Myeloproliferative Neoplasms V.3.2019. © National Comprehensive Cancer Network, Inc 2019. All rights reserved. Accessed September 4, 2019. To view the most recent and complete version of the guideline, go online to NCCN.org. NCCN makes no warranties of any kind whatsoever regarding their content, use or application and disclaims any responsibility for their application or use in any way. 6. Stein BL, Oh ST, Berenson D, et al. *J Clin Oncol*. 2015;33(33):3953-3960. 7. Barbui T, Masciulli A, Marfisi MR, et al. *Blood*. 2015;126(4):560-561.

