



**BBGuy Essentials 083CE:
Building the Perfect Transfusion Committee with Carolyn burns
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Carolyn: Hello, I'm Dr. Carolyn Burns, and this the Blood Bank Guy Essentials Podcast.

Joe : Hi everyone. This is episode 083CE of Blood Bank Guy Essentials, the podcast designed help YOU learn the essentials of Transfusion Medicine. My name is Joe Chaffin, and I am your host. I'm going to tell you all about how to build a perfect transfusion committee with my guest, Dr. Carolyn Burns, in just a moment.

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OK, before we talk about transfusion committees, let's address the proverbial "elephant in the room." As I'm recording this, in April 2020, everyone in the entire world, for good reason, is worried about the COVID-19 pandemic. The statistics are ... they're awful, and they're crushing, and honestly I'm just like all of you, I'm worried about my family and friends, too. Truthfully, my day to day responsibilities at my blood center in Southern California have just been overwhelming. The stories that we read, and hear, and see about devastating loss everywhere just break my heart, and I'm sure they do the same thing to you. I admit, I'm a really, really emotional person, and I've felt like my insides are being torn apart just about every day for the last six weeks or so. So, if you have lost someone that you love to this stupid coronavirus I am so, so sorry. I send you my best and my most heartfelt thoughts and good wishes for comfort for you, your families, and anyone that's been impacted directly by this.

But despite all that, we have to live, we have to keep going as best we can. So, to that end, I thought I would share an interview with you that I did before COVID-19 was even a thing with my friend, Dr. Carolyn Burns. Carolyn is an expert in patient blood management. In fact, she's currently the president-elect of the Society for the Advancement of Blood Management, or SABM. She works as a patient blood management consultant for Accumen, and she is incredibly passionate about helping hospitals understand just how to improve, well, really, all of their practices surrounding blood management including developing excellent, engaged, and believe it or not, USEFUL transfusion committees.



So, no matter where you are right now, Carolyn has some tips that'll help you make your transfusion committee better. If you don't have a transfusion committee and you don't understand why you might even want or need one, guess what, she can help you with that, too. So, let's listen to my interview recorded pre-COVID with Dr. Carolyn Burns on "Building the Perfect Transfusion Committee."

Joe: Hey, Carolyn, welcome back to the Blood Bank Guy Essentials Podcast.

Carolyn: Yeah, thanks, Joe, good talking to you.

Joe: Always great to hear your voice, my friend. Well, it's been how long? Like a year or so since I last had you on the podcast, a wonderful conversation about patient blood management, and everyone, before I say another word I want to make sure that if you have not heard the talk that I did with Carolyn on patient blood management that's at BBGuy.org/067. It is fantastic, and Carolyn waxes eloquent on a lot of the things that we're going to allude to today, and we'll touch on them a little bit, but I just want to make sure that everyone is aware of that. You can get free continuing education for that episode as well, so I mean, what a bargain, right, Carolyn? I can't believe it.

Carolyn: Absolutely.

Joe: Man, oh, man, that's fantastic. All right, so today I want to talk to you about building the perfect transfusion committee, and I think that this is a timely topic, and one that's, for me, very, very interesting in my role as a blood center medical director, because I go out and I see a lot of hospital transfusion committees, and I see a wide variety of them. Can you talk to us a little bit, Carolyn, about in your role as a consultant to different hospitals, is that your experience as well?

Carolyn: Oh, absolutely, and it's interesting, too, Joe, that you say it's timely, because when you got ahold of me to pursue this particular session, I had already been asked by two other groups to provide some similar presentations and insights, and I think it is because all of us are recognizing that perhaps we don't have a very effective committee, or we want to better engage our members on those committees, and how do we really do that? How do we sustain it, and drive it forward, because I think folks are recognizing that perhaps are we falling short in some ways? Are we not doing the best we can do? Are there other things we should be looking at to reinvigorate ourselves, and to provide that better patient care through that committee process?

Joe: Yeah, absolutely, and I think that really, for me, the groups that I see as I go out to hospitals and I talk to people in my area in Southern California about transfusion committees, and about transfusion review, and some of the things that we're going to discuss, I kind of see three different types of organizational approaches to this. There are places that I go to that don't currently have a transfusion committee, there are other places that I go to that have a transfusion committee, but it tends to be three people from the lab and a pathologist sitting around staring at each other, which isn't necessarily the most effective thing in the world, and every now and then I'll see hospitals with wonderful, integrated transfusion committees that are deeply involved in patient blood management, and that's fantastic.

Quite frankly, those of you that are listening, if you are in that third group, if you have a wonderful, integrated patient blood management type committee, that's fantastic, congratulations, we're so happy for you. Keep listening, because I hope you'll learn stuff, but this is really focused primarily to those first two groups as we discussed, those that either now don't have a transfusion committee, or those who have what I would call an ineffective transfusion committee. So, Carolyn, let's move through this, let's talk just the very basics to start with. What actually is, in your view, a transfusion committee?

Carolyn: Well, I see a transfusion committee, whether or not you want to have the moniker of a "patient blood management committee," as a dedicated group. Certainly it tends to be a physician-oriented committee, because it typically, as well, in most organizations would be required by bylaws of the hospital facility or system to report to the medical executive committee. So, I see this as potentially really more physician-driven, but very multidisciplinary, with other healthcare providers as a part of that, that really sees the role as not just checking boxes, and looking at inventory, or blood utilization, or even wastage, but going far beyond even some of those minimal requirements that we have for laboratory accreditation, or even by federal law in some cases. But really thinking outside the box as to how do our activities of monitoring transfusion and other patient blood management initiatives, how do they change outcomes? How could we apply the evidence, and educate ourselves, and move the committee and our other colleagues to identifying the effects we have on our patients every single day in terms of their safety, and their outcomes, and potential of avoiding harm?

Joe: Right, absolutely. As I talk to hospitals about transfusion committees, especially those who currently don't have one, I get pushback sometimes, Carolyn. So, I will ask you a very simple and straightforward question: In

the United States, is it REQUIRED that a hospital has a dedicated transfusion committee?

Carolyn: No, and I'm glad you asked that, and I could tell you from experience, I did not. In my 20 years of private practice at Jewish Hospital Healthcare in Louisville, I did not have a freestanding dedicated transfusion committee. We ran ours through quality, because you are correct, there's no requirement that you have to have that dedicated committee. There are requirements, elements of performance, standards, etc., that speak to the fact that there must be transfusion activity oversight, and that comes, as you well know, through many different sorts of organizations, whether that's, again, FDA, Joint Commission, all of us in the laboratory world know College of American Pathologists, AABB, etc. But you are correct, as long as you are performing the duties and responsibilities of transfusion oversight, and all the key points beneath that, then your review or your process can be in any way that fits your particular hospital facility.

Joe: And that, I think, is the key, and to me, I think you said something very important there, and that's that "if you are doing all the things that you're required to do by the various organizations," and we're going to get to that in just a few minutes, then you're fine. But, folks, if you're sitting there, this is just me speaking my opinion for a second, agree or disagree in just a second, Carolyn, but in my opinion if you're sitting there, and your "transfusion review" is five minutes in a pharmacy committee, or three minutes in a quality committee where, "Yeah, all's good, yay, move on.", in my opinion you are woefully not meeting those requirements. What do you think of that, Carolyn, is that too strong a statement?

Carolyn: No, I would completely disagree [that it meets the requirements], and again, just from my own personal experience, it's not that I didn't think, Joe, that for me, in the role as the medical director for pathology and transfusion medicine, and the folks in my pathology quality review committee, it's not that I didn't think we were doing a good job, we were "dotting our i's and crossing our t's," however, I did always feel that we kind of lacked that multidisciplinary insight. I had to get pretty comfortable with driving my own bus.

And not that I want to say I didn't try to do it well, because of course I wanted to do it well, but I spent most of my years longing for that type of a committee that was really, again, focused not just on those ... yeah, just looking at each other and saying, "How much should we use this month?", or, "How much did we waste this month?", and, "What were our dollars?" I really would've love to have had a broader sweeping scope of practice. So, I think, if that's kind of what you're doing, then it's insufficient, even if your

accrediting body says, "Oh yeah, you're doing all the things that you're kind of sort of supposed to do."

Joe: Yep, so it's more than checking boxes, I completely agree with that. So, before we get to some of those requirements for review, Carolyn, I want to give you the floor for just a moment, and as I mentioned everyone, BBGuy.org/067 for Carolyn's full thoughts on patient blood management, but for those who have not yet listened to that, Carolyn, and want to know what we're talking about when we say "PBM," can you give us the quick thumbnail on what is PBM, and how does it relate to what we're talking about today?

Carolyn: Yeah, sure, patient blood management is, essentially if you want to look at the definition, or the scope, the vision, the mission is essentially landing on four pillars. One is diagnosis and management of anemia. The second one would be minimizing bleeding and blood loss by optimizing coagulation. The third pillar, and we're going to talk, I know, a lot about this, is a multidisciplinary approach to perhaps incorporating alternatives, other strategies that might help to limit or eliminate the need for a transfusion knowing what we know about the risk benefit ration nowadays, and all of this rests on that fourth pillar as well, which is a patient-centered approach.

All of that involving that informed choice for our patients to be part of that discussion, and ultimately all four of those pillars, your ultimate goal, your utopia, is what you're aiming for is better patient outcomes. So, of course your transfusion committee, or patient blood management committee, by its duties and responsibilities, their charter should be to incorporate the best they can those pillars of blood management. So again, as you've mentioned, it's not just sitting and looking at just use of blood products, and C:T ratios, and things like this. It goes far beyond, how are we doing in those pillars? How are we broadening our horizons in terms of reaching out for better patient care?

Joe: Well, I love that, and that really, I completely agree, is where we all should be thinking of going, and we're going to talk a little bit about how to get there. One thing before we start down that pathway, I think there's something that has been huge in my mind ever since I heard Sunny Dzik talk about this in the, I believe it was the 2002 AABB Annual Meeting, the Emily Cooley Lecture, and it was published in TRANSFUSION in 2003 where he talked about the difference between "blood safety" and "transfusion safety," the difference between just looking at is there HIV in the blood, for example, to looking at the whole process. Can you talk about how that relates, not only to what we're talking about today with

transfusion/PBM committees, but just in terms of our whole goal as we're doing this whole thing?

Carolyn: Yes, that's such a wonderful, wonderful article, and Sunny really ... I mean, it still resonates today just like it did back in 2002 when he gave that lecture. It was outstanding, and I'm glad you brought that up, Joe, because yeah, when we look, and in effect this really feeds into patient blood management, and where we've gone into this whole concept is that if you look at transfusion (and you know this better than anybody because you're at a donor center), the blood donor centers do a magnificent job of providing blood safety. On your backs are the provision of our blood products, and the testing of our donors, and the testing of our products, and the sterility of our products, and the transport to us of those products.

But if you really look at the scope, at the scale of the entire process, again, two thirds of that really rests with those of us that are making that medical decision to transfuse, and those that work with us to administer the blood. So, we're really talking about the medical decision to transfuse incorporates and is going to set the whole process into action. We're going to test that particular blood component and cross-match it. We have to have people that can safely issue it, transport it. We have certain transportation requirements, et cetera. And then of course, we can't forget about our nurses who, probably 95% of transfusion is performed by nurses, it's not performed by us physicians that are ordering the blood, and they have to be with the patient, and monitor the patient, and then we have to continue to monitor those patients not just through the transfusion but beyond.

So really, it's that, and it sounds a little kitschy, but it really is that "vein-to-vein" transfusion safety chain, if you will, it kind of pushes us down this road to say, "The transfusion committee and patient blood management should not just be product-focused. We need to be patient-focused." So, I think Sunny really had that whole concept in a nutshell in that particular presentation, and ultimately that publication.

Joe: And those of you who have not managed to read that article, Sunny published it, again, it was in the journal TRANSFUSION in 2003. I will put that reference everyone on the show page for this episode, so please, please read that if you haven't. It's marvelous, it was really a landmark talk. I can't tell you ... I'm sure you feel the same, Carolyn, I can't tell you how many times I've referred to it and seen other people refer to it. It's just ... it's tremendous, I can't overstate that. So, you've got to check that out everyone. So, show page for this episode, BBGuy.org/083.

All right, Carolyn, we need to jump back to the "why" and to the "what" kind of things we need to look at and what the requirements are. Just to summarize, everyone, we've said you don't necessarily have to have a dedicated transfusion/patient blood management committee, however you have to be doing the things that are required of you. So, that's where we need to spend a few minutes. Carolyn, what are those things that are required, and by which organizations?

Carolyn: Yeah sure, so in a sense, if you want a justification for the benefits of having your committee, or continuing, and sustaining, and moving forward with your committee, sure, and even historically, we know that there's been a call to action even since the 1930s for some sort of review process for transfusion. Ultimately that kind of culminated as we came in through the 1960s, 1970s. The Joint Commission, of course, put out that there was a need for transfusion practice review, and the Joint Commission does provide "elements of performance," as they call them, for what is required, in their view, as an accrediting body for hospitals, and infusion centers, et cetera, for that sort of transfusion review. Of course, again, those of us that are in the laboratory we know as well, we have those additional elements or performance standards, accreditation checklists, if you will, through College of American Pathologists, and AABB.

So, some of those include, if you look at FDA, of course FDA does require, and this really lands in your lap, too, Joe, again, being at a donor center, you all are highly regulated by law, by good manufacturing processes that takes into consideration registration, product licensure, error reporting, et cetera. If you look at CMS, and we all know that CMS is in our lap along with CLIA, that also speaks to certain registration requirements, certifications, inspections. Then we get into the accrediting bodies, like Joint Commission, or if you're HFAP, or DNV, all of them have similar standards or elements of performance that they want your facility to meet in terms of oversight of transfusion practice.

And then again, AABB and CAP, if you get into the nuts and bolts of that, CAP alone with their one standard, if you will, on their laboratory checklist for you to be accredited by them, which by the way, CAP has deemed status with Joint Commission, they have a huge long paragraph of what just is expected, what are the duties and responsibilities for the medical director, the transfusion alone, and it is broad. It encompasses all transfusion practice within your inpatient and outpatient facilities. So, it's a lot of activity and the devil's in the detail, and then if you look at some of their standards, it's not just for what happens in the blood bank, again, it's perioperative, you look at AABB.

Joe: That one always gets people, doesn't it? Yes, I mean, when you go into and you do ... I, like you, I'm sure, have done many CAP inspections, and when you go in and you talk to typically pathologists, not always pathologists, but people that are in charge of the transfusion service, and you mention to them, "Well, what are you doing with perioperative?", and they look at you blankly like, "What? That's not my deal. What are you talking about?", right?

Carolyn: Yeah, exactly, and it really does fall under your purview, and I think as the medical director that also ... Let's make this point, if you take it then to, what are these things then that the members on your transfusion committee need to know? I'm not suggesting that every clinician, let's say, that's on your transfusion committee, every nurse, every risk manager, and we'll get into that composition of who should be on your committee. I'm not saying that everyone has to know the regulations, the standards, elements of performance, perhaps, such as your medical director of your transfusion service does, or your blood bank supervisor, but they need to understand the concepts, and be cogent enough to speak to ... Again, this is the why we need to do that. We always have to step back, as my one colleague always says, "Always ask the why's", because these things are important, they're there for patient safety. So, you don't have to know all the details, but it's good to understand that concept behind transfusion safety oversight and what is required by these different organizations, and inspecting bodies, et cetera.

Joe: Yes, absolutely, finally, what about AABB Standards? Obviously not everyone is AABB accredited. Where I live in California it's state law that everyone has to follow AABB standards, but what kind of things does AABB ask us for?

Carolyn: Oh yeah, so AABB, they get deep into the weeds as well, and this would include everything from ordering practices, to processes around patient identification, sample collection, near-miss events, other adverse events, usage and discard, and reasons for wastage, appropriateness, and I know we'll talk about that, blood administration policies, are they aligned with your patient safety and quality risk assessments? Compliance, and all sorts of peer review. They make a pretty strong statement that if you're following their standards, this is for all categories of blood components.

So, in other words it's not just you look at your red cells, we all know you need to look at plasma, platelets, cryoprecipitate, even if you're looking at fractions, et cetera. And this isn't a well, kind of, sort of, maybe you should do this, this is a should be monitor, and I think intuitively we all know that. But it's, again, a good way if you're trying to get your committee started, or

get it, again, reinvigorated, go back sometimes and review some of these items, because I think it'll make you realize that ultimately the benefit of your committee is that you will really help maintain those compliance and regulatory requirements, even if peripherally so, based on your subspecialty, and you'll understand that it improves that patient safety and efficacy.

Joe: And so, Carolyn, I know there's an organization that's very near and dear to your heart, the Society for the Advancement of Blood Management, and you're like the president-elect of SABM, isn't that right?

Carolyn: Yes, yes, I am, and it's such a wonderful group. I've been so honored to be around the amazing people that are in that professional society. It's crazy cool.

Joe: I'm guessing that SABM has weighed in on this as well. Does SABM have any thoughts on what transfusion safety oversight should look like?

Carolyn: Yes, they do, and in fact, SABM, by the way, if you go on their website you can see some of the resources they have there in terms of quality guides, and they actually have standards. In fact, they're on their fifth edition was published late 2019, for their standards for patient blood management. As a part of that, they do talk about the transfusion/patient blood management committee, and that it needs to be patient-centered, it should have a physician as a medical director, it's a multi-specialty steering committee, are their words.

They look at approving policies, procedures, protocols. Again, defining ... this is what I love, and it's the sense asking for a charter, what is your committee scope, your mission, your vision? What are your values? What are your practices? And again, continuous oversight, whether that's reviewing some sort of policies, procedures every year, taking on projects like anemia management, and correlating those with patient outcomes. So yes, they have an entire subsection on transfusion safety oversight.

Joe: So, I think that we both fall in the same category here, Carolyn, I'm pretty sure I can speak for you when I say that I believe that both of us feel that having a dedicated transfusion/patient blood management committee is probably best practice, and probably the best thing. But in terms of ... If you were coming to someone and saying, "Okay, here are several things that are really just in a nutshell the reasons why you should consider having a dedicated committee," how would you answer that question?

Carolyn: Again, I think that the focus of your committee should be that you help to maintain, of course, as we mentioned, those regulatory, or compliance

issues that one must do within your facility, but looking also at improving transfusion safety and efficacy in an evidence-based manner, and managing, of course, any patient blood management activities. We've talked about a host of things. I think ultimately what it does, it provides consistency for your evidence-based transfusion and patient blood management practices.

Joe: All right, well, so I'm right there with you, I completely agree, and I hope we've convinced anyone that's a doubter out there that there is really a benefit to having a dedicated transfusion committee/PBM committee, but I'm pretty sure I know you well enough to know that you're not satisfied just with that. Having a committee, as I said before, is not the same, necessarily, as having an effective committee. So, I think that we need to help people ... I mean, the title of this interview is "Building the Perfect Transfusion Committee." So, let's do that, let's talk about ... for those who are just starting, and for those who already have a transfusion committee that they think needs to do more, what to you is the first characteristic of an effective transfusion committee?

Carolyn: And some of these thoughts, by the way, I'll just pitch this out there, Joe, some of this really came to me because I was lucky enough to be a part of the second edition of a wonderful book, "The Transfusion Committee: Putting Patient Safety First," and it was edited by Dr. Saxena, who I believe is still in the Southern Cali area. But it's a wonderful publication from AABB press, and I would recommend it to anybody that's looking for kind of the blueprint. So, some of my comments are really based on it, because as I read through the book, and prepared to kind of help out with that newer edition those few years ago, again, these things resonated with me about ... in a sense with what was I lacking at my own institution?

So, they really speak to things, and the first thing is, and we've already used this word, it needs to be **MULTIDISCIPLINARY**. As much as I loved in my practice having my blood bank peeps, and my lab administrator, and me waxing philosophically, and doing our best to monitor all these things, I really felt I would've done so much more, I could've moved light years ahead, had I had a multidisciplinary team. I see that as being a membership that reflects your medical staff, your nursing staff, it needs to be different subspecialties, et cetera.

Whenever I go and help client hospitals, I'm like you, I don't want it just to be those couple of people, I really want to see physicians, I want to see administrative champions, certainly lab, nursing. How about perfusion? These people are giving blood in your ORs, we want quality and risk management. Oh, my goodness, don't forget your pharmacist. People that

know me, know I'm always saying, "The pharmacy is your friend," and there's so many patient blood management initiatives that come through pharmacy. Just think about what your pharmacy houses in terms of your fractions that you might use. Have an IT person from time to time, because when you're building guidelines and embedding this into CPOE, you have to have IT, they need to be on your team. You have to occasionally have a finance person. Your bean counters do matter. They do help you be fiscally responsible, and help you with budgets, and we have to be that way.

I'm always going to put in a plug for the donor center. Again, if you were in my region, I might ask you that you have to be there at every one of my quarterly meetings, but I certainly would reach out once a year, because the donor centers have unbelievable new processes, components, things that are going on in your world that we need to incorporate and learn.

And from time to time I'm one of those people that I say, "Ask some of your biomedical people to come on your team." That's multidisciplinary. They're the people that take care of your rapid infusers, your blood warmers, all of your refrigerators, your freezers, all those things. They need to understand how they fit into the scope of transfusion practice, and how they help to maintain safety, and I'd say the same for transport staff. They need to understand why they're so key to that whole idea of proper patient identification, and delivery of our components to the correct OR suite, et cetera. Again, some of these people don't have to be there every time, but that's really how you build that committee is get all the people to the table and play to their strengths.

Joe: So, one of the things that you mentioned, and I'm going to come back to that donor center thing in just a second, because obviously that's near and dear to my heart, but the administrative champion, and I think that in my opinion, Carolyn, a lot of the success of your committee depends on having some buy-in from administration, and I wonder how, in your experience, have you gained that? How do you do that? How do you find someone in administration that's going to get passionate about what you're doing, and help you to actually move the mission of your transfusion committee forward?

Carolyn: Yeah, well, and that's hard when you're trying to engage anyone, but yes, particularly with administrative folks, because sometimes we do tend to keep clinical and administrative duties in separate, using that word we always use, in different "silos." But sometimes I found that in approaching the chief medical officer, because most often that is someone that has been clinical throughout their career, understands what the clinical team wants, and understands perhaps that scope of practice, and then can be

that interface with other non-medical administrators. I have been at some places however that there's been a vice president of clinical practices that ends up getting really excited and juiced over this.

I can tell you, one of my administrative champions was actually, for a period of time, we had the president of our hospital who had really been involved with establishing the Bloodless Program, and although that gentleman didn't always come to, again, my kind of fragmented quality meetings, but certainly he was always asking, because he had this special interest in Bloodless. So, as we started to expand into patient blood management, he was always a little bit piqued. So again, just going around and trying to find that person, and I would agree, attitude reflects leadership as they say in that movie, Remember the Titans, and you need leadership from all different areas of your hospital, including administration.

Joe: I agree, and just a little side tip for everyone out there, I will say this, and this is me being perhaps a tiny bit devious, but I don't think it's being devious, Carolyn; oftentimes if you point out some of just the raw monetary savings that effective patient blood management tends to result in, again, that's not our goal, we're not trying to save money, we're trying to save patients, I fully am on board with that, but sometimes pointing out some of those monetary benefits that have been reported in the past can get administrative people, not necessarily the medical administrative people, but the "administrative" administrative people more interested in the process. Is that a fair way to put it?

Carolyn: Yes, and I don't feel badly, and I say this very often, what is so wrong, or why can't we view this as a win-win? If I could get better, safer, more effective care for our patients through PBM, and best transfusion evidence-based practice, and be fiscally responsible, why not? So yes, if you could get one of your C-suite people to get that touchpoint, and that's their reason, well, then I'm all for it, bring them to the table.

Joe: Oh, I agree with you. I agree with you completely. So, I do want to mention the donor center thing, we're going to talk more about, when we get to the next point about bringing additional medical staff people in, but let's just make a quick point about donor center people. So folks, I don't have much of a question here, Carolyn, other than I want to give my opinion for just a second. As a donor center physician, I can tell you that I 100% agree with what Carolyn said, you don't necessarily have to have your donor center doc at every meeting, and in fact, sometimes they won't be available to be at every meeting.

But having them there every now and then to keep you up to date with new things that are coming down the line, to help you understand how to integrate with the donor center, to help understand when supplies are limited, and most importantly from my perspective, to build a relationship with that donor center doc, so that when you have trouble, or when you have a case that might be transfusion-related acute lung injury, or you need help with something that's going on in your hospital, those donor center doctors can be a wonderful resource. So again, I don't really have a question there, Carolyn, other than just to say I agree that I think it's vital to get your donor center docs involved.

Carolyn: I do, too, and I think in particular in this day and age with so many new processes and products coming out, it's hard to stay on top of those things, and as you mentioned, I would agree in terms of provision of products. I personally had a wonderful relationship with our donor center medical director, who was always ... I could pick up the phone, and even our component lab people, our reference lab people, they were a stone's throw away from us, and were always willing to help guide us when we had questions and concerns. So, sure, get that person again, give them a seat at the table.

Joe: Yeah, for sure. Okay, so your first characteristic of an effective patient blood management/transfusion committee is that it is multidisciplinary. What is number two, Carolyn?

Carolyn: Yeah, number two is to be **REPRESENTATIVE**, and this is where, again, it feeds into that concept of being multidisciplinary. You want to have strong representation of physicians and nurses from different subspecialties, and in particular those subspecialties that are touched by transfusion and ultimately patient blood management strategies. I don't mean to be glib, but, again, for people that know me they know I'm married to a physician, but my husband is an ophthalmologist. I'm not going to tell my husband, Frank, that he's the person I really want on that committee, because he doesn't transfuse. He just flat out will not, I mean, it doesn't affect him.

So, that's not ... even though they might be willing, what you really want is the guy or the gal at the table that has been touched by transfusion, that needs to understand it, and wants to learn about it, and wants to participate in that, so we're really talking about cardiac surgery, trauma surgery, general surgery, anesthesia, our critical care docs, our hematology/oncology docs, ER docs, your Ped/Neonates, and this means also outpatient and inpatient representation, because we know a significant amount of transfusion goes on in our outpatient infusion centers, or even in physician offices.

So, incorporate those kinds of people, and it kind of leads to that next thing that if then you're going to do a committee chair, as much as I'm not bashing pathologists, because obviously I am one, but it's kind of nice if you have your chair, or at least a co-chair not be your pathologist, but be, again, one of the physicians or clinical care providers that is from one of those subspecialties. It just brings a little bit of credibility, I think, to the situation, and it's get that clinical conversation going so you feel that you are truly incorporating those clinical colleagues and it's not just something that's an initiative from the laboratory.

Joe: So, I have to tell you, Carolyn, the cynic in me, and I'm sure the cynic in some people sitting out there listening right now, is saying, "Okay, seems like a great idea, Carolyn, it seems like a logical 'perfect world' scenario, but man, when I talk to my doctors they're way too busy, and they don't want to 'waste their time' with a transfusion committee." So again, in your experience, you've consulted with places on doing this, you've established them in your own hospitals, how do you pitch this to your clinicians so that they understand that there's value here?

Carolyn: Yeah, wow, yeah, it's kind of what you're asking me is what's the "secret sauce," and I'm not going to tell you I've cracked that code completely, I will just admit to you I haven't gotten there quite yet with every place that I've ever worked with. But I think if the group sits down, the little nugget formative group sits down, and you start to list pen to paper of the different subspecialties you want, I think looking in each of those departments, because when you're at your facility, you know the doctors and nurses that you might like to approach, and some of them you may have to take a little bit of a different tack than others, always I think having them understand the why you feel that it is important for them to be there is good.

But in particular, if you can speak to them in terms, again, of their strengths that they would bring to the table, and also assure them, and we're going to get to this later, assure them that you are going with this committee, you will do your best to minimize the amount of time that is wasted. I mean, this has got to be a group that's very focused, it's got to be action oriented and focused, and sometimes you can snag that particular physician. The other thing to do is sometimes the physician or the nurse that's been a naysayer, oh, that's the perfect person. We welcome controversy, that's why we want you here. So, sometimes playing that card can really be advantageous, and I've seen it happen where the person that came in being the complete naysayer of A, B, or C concept becomes your biggest advocate.

Another thing I think to pitch out is, yes, within your department you might be the go-to person that is listed on the committee, but if, in fact, you can't

be there, because your clinical care duties are not allowing for that day, something happens, we all know, patient safety comes first, it trumps everything, but have one of your partners go. See if one of your colleagues within your department can go. That also is a good way to get a little bit of potential onboarding so as you roll off that committee perhaps in your term, someone else has already been around to understand the concepts.

Joe: Yeah, yeah, for sure. I think there's a couple of really important ... Well, actually, all of that is really important, the one thing that I'll just zero in on for a second, and again, I know we'll come back to this, is the focus. I'm convinced that if you try to convince a clinician to be a part of a committee, and you tell them, "You'll have to do this, and you'll have to do that, and you'll have to do the other thing," that sounds administrative to them, they're going to fight you. They're going to resist that and not be interested.

But if you keep it focused, and we're not going to waste your time. I love what you said, "We're not going to waste your time.", and sell them on the vision, I think that's the way to go. So, I'm right there with you, Carolyn, in terms of what you're saying. Well, so we've talked about the first two characteristics that they should be multidisciplinary, and representative. Let's hit the third one, what do you think that the third characteristic of an effective committee should be?

Carolyn: Well, this kind of feeds in to what you were saying about if you can get them to buy into the concept. So, this is the whole idea about being, and it's pointed out again in that Saxena book, is being **ACTIVISTS**. This is not, as you mentioned earlier, two or three people sitting around a table having pretzels and a Diet Coke, and looking at data, it's not. You have to truly, truly believe, and I know people probably think I'm nuts, but I want people to truly believe when they come to that table, and they're part of this committee, that you are coming to be active in this. This isn't a, "Ho-hum, oh yeah, let's just meet a little bit and talk about something something." This means you are 24/7, 365 days out of the year, I don't mean you're on call, that's not what I'm saying, but it means in your brain and in your heart you are truly committed to appropriate transfusion, evidence-based transfusion, and additional patient blood management strategies that can improve patient care. I am here for patients, so let's go get them.

So, you have to have the group really feel that patient blood management is not an option, and in fact, if you're not doing it, there's been a recent editorial that speaks to it as substandard care. So, feeding each other as caregivers to understand we are actively promoting better patient outcomes.

Joe: That's fantastic, I love that, I could not possibly agree more. I don't think there's a whole lot more to say about that, Carolyn, I think that's massively important that you have to have a mission, and I think maybe we'll get to that a little bit in the next point, but there has to be something that you're shooting towards, and that is, as you said, the goal of we're trying to do something here, and as everybody understands that, that makes it much easier for everyone to row in the same direction, so right there with you.

Carolyn: Yeah, and I think it kind of brings up an idea about charters. I've noticed that some very, very successful transfusion committees have actually put, again, pen to paper, made a charter, and at the beginning of their meetings they re-read ... someone reads out loud their mission/vision statement. So again, it centers everybody from the ... It's kind of how other committees use safety stories, something like that that really makes you recall, "Wow, this is the purpose. This is the reason I'm here."

Joe: Yeah, oh, I love that, love that. Okay, so we've talked about being multidisciplinary, being representative, having an activist role, and then the last one is kind of an interesting one, and you've talked, and that book in particular talked about the three wells, what are the three wells? What does that mean?

Carolyn: Yeah, so they're well-planned, well-focused, and well-documented, and this really speaks to this whole idea, again, of let's be on time delivering agendas, and let's stick with agendas. Let's have our minutes, send them out, get action items, have everyone be able to review some of those documents before you come in the room, so again, we're not wasting time. We want all those reports to be available, so you do have to be very organized. And to plan for your meetings, plan ahead for the meetings, and keep everyone on top of that commitment to that meeting.

And then again, focusing. What are the ... let's say you've chosen, because of your mission for your particular committee that year, you have focused on three key performance indicators. Just focus on those key performance indicators. Sure, you can have data on usage, wastage, other things, dollars, whatever that happens to be, and that can be in the sense for information, and if there are trends you can focus on those. But try to really keep it to those projects, or action items, those key performance indicators, and document those things so everyone knows where you are.

I think we all know, Joe, I've been a part of these meetings, too, that you're going, "Oh, my gosh, this is like moving at a glacial pace, and all's it's doing is wasting my time, and I'm going to start checking my phone." We don't

want that, so I think really everyone committed to being well-planned, well-focused, and well-documented.

Joe: Agreed, and I think the faster the pace, within reason of course, but the faster the pace, and the more things feel like they're moving and the less things feel like they're dragging, the better your repeat attendance is going to be, in my experience.

Carolyn: Yeah, and also by focusing on those things, then when you have something fabulous that you've done, you've completed a project, you're shown those better outcomes, you celebrate those, and that, again, feeds the group. It keeps us all moving down that ... we're excited about that, so what's next, in other words. So, it just keeps that fervor and that feeling of we're doing a good thing here.

Joe: That's fantastic, Carolyn. So, I think as we close out our time together I want to focus in on a slide that you made that you were kind enough to share with me, and we're going to share with our audience today. Everyone, Carolyn put together a slide that talks about the kind of things that effective patient blood management/transfusion committees need to be looking at, and need to be focusing on, that will be on the show page for this episode, again, BBGuy.org/083. But Carolyn, I wonder if you could just kind of hit the highlights of that for us. What are the kind of things that as you're putting together your agendas, as you're putting together your plans, and maybe even your charters, what should people be looking at in order to be one of those effective committees?

Carolyn: Yeah, sure, and when they look at the slide some of these are things that we know, again, by either regulation, or standards, element of performance, you really need to be looking at it. Let's face it, everyone's probably going to have ... within their blood bank they're going to look at their C:T ratios, and those can be useful. You can look at your percent of single unit transfusions for your red cells, and even for platelets, because we know the new evidence really speaks to, "Why give two when one will do?"

I think looking at transfusion documentation, your nurses know they're required to document, anesthesia knows they have to document, all of those things we know we need to do, and those can be very informative. Blood wastage, very important, and I would suggest always putting a reason for that wastage, because again, it could provide a focus for where you need to work. How could we work on this so waste less?

But let's expand that horizon now to looking at things like transfusion appropriateness, use of transfusion guidelines, peer review. Do you have way to benchmark by blood utilization, by DRG, service line, 1,000 patient days, things like that that some facilities do have the capability.

And then you move into some more broader concepts of blood management. How are we doing our informed choice process, and listen to my words, informed "choice," not informed consent. Use of pharmaceuticals. Here's your pharmacy again, are we incorporating those? How are we doing that? How are we using cell salvage? Acute normovolemic hemodilution? How are we using topical hemostatics? Are these, again, anemia management, where are we with laboratory services so we avoid iatrogenic blood loss from phlebotomy? How about educational oversight? What do you do for your fellow clinicians and care providers to continuously educate them? That could be a great role for the folks on your team to be participating in.

And again, I'll say donor center services, how are you interacting? Do you have a regular meeting? Do you have a liaison, and how is that going? How is that improving your patient outcomes? So I think all of these things, some of which are very common and people know they need to do them, and some are more conceptual, but can be very formative and transformative for your facility and for your patients.

Joe: I agree, and I have to tell you, and this is just me as a personal aside, I, like you, have sat in a lot of transfusion committees over the long time that I've been doing transfusion medicine, I can't remember the last time a C:T ratio actually was incredibly useful for me, but maybe I'm different. But that's one, while people do, and I get it, honestly I rarely find a ton of value in it. I don't know, maybe I'm an outlier there, Carolyn, what do you think?

Carolyn: Well, you know what? Here's the only reason that I didn't mind watching the C:T ratio, but it was very specific for us at my institution at the time, because we were moving towards more of the physician order entry, and standard paper order sets, and what I started doing is looking at C:T ratios, and the physicians that had high C:T ratios I started talking with them, and what I would do is essentially say, "Well, I applaud you in one sense, Dr. Jones, because having a high C:T ratio means you're not transfusing, right? Congratulations, thank you. But what it's telling me is you're wasting the time and money to cross-match that patient when you don't need to."

So, what it did was it fed us back to developing a maximal surgical blood ordering schedule. It also fed back into, because some of those physicians looked at me and said, "Carolyn, I never order a type and cross-match for

that type of case, and you know what we found? We found that we had old standing orders that were out there, we found something as simple as, in our computer, "T and C," for type and cross-match, was alphabetically above "T and S," for type and screen, and our unit clerks were just probing the first one they saw. So, some of these little things, you could do, and you know what? We saw every one of those doctors that had those high ratios, boom, they came down when we started to clean up the house. It was pretty insightful. So, you never know, never know.

Joe: So, I didn't say don't do it, I just said I haven't found it terribly useful, okay? Fair enough, I stand corrected. Okay, so I would like to close with this, Carolyn, this topic that I'm going to bring up to you is one that we could spend an entire hour on by itself, so obviously we don't have that kind of time, but I do want to talk to you about what I think people perceive as one of the areas where conflict can come up in this entire process, and that's specifically the peer review of transfusion appropriateness, and transfusion order guidelines.

So, again, without being able to go enormously into it, I think a lot of hospitals see that as a barrier. Quite frankly, they're a little afraid of that, how are we going to do that? Now granted, as we already talked about, you're required to do it, but can you share some tips with us, some practical tips on how we do this, how we implement guidelines? Is it enough to just say, "Okay, here's our guidelines, everybody. Yay, everybody follow them." How do you move that into practice in your hospital?

Carolyn: Yeah. Well, the biggest success that I've seen that I've been able to have, and that's when ... also, by the way, it's not just me, I have to say, I worked with some amazing people with companies that asked me to come in and help, and their clinical leads are fabulous at change management, and also the people, boots in the ground, that are in the facilities, so I have to give a shout out to those folks that really get it. It makes my job a whole lot easier. But I think most of us, as far as our clinical colleagues, physicians, mid level care providers, nurses, and our laboratorians in particular, we learn best if we understand the state of the science. We want to know the why. Tell me why, show me the evidence. Show me the money. Not literally the money, but show me the stuff here, Carolyn.

So, very often it seems like the more successful implementation of better transfusion and better patient blood management practices are formulated in the state of the science. You get people to read and understand that literature, and say, "Aha, now you've told me the why, now how do I go do it?" So, once they understand, let's say red cells just in this case, we all

know the literature, and we've presented the literature, we've discussed the literature, we agree with the literature in principle and practice.

So, now we're going to build, based on that evidence, what are our guidelines, potentially embed them into CPOE, and we always know that there's going to be that patient that doesn't fit the textbook definition. So, when you start to do that, and you agree to those guidelines, and now they're in your CPOE, all of the folks on your medical staff, nursing staff, et cetera, have to understand, yes, you're going to use some of those ... that data. Let's say you're pulling data on how many patients have hemoglobins above 8 [g/dL] and are being transfused. Well, you can look at those individual cases, and that's where your multidisciplinary team comes into play, because as a pathologist I might not understand the particular characteristic of your cardiovascular surgery patient, so we can bring those things to that entire group, and scratch our heads, look at the chart, say what's going on.

The other good news is this isn't supposed to be used as punitive. I would say that if you start using your guidelines and looking at appropriateness of those guidelines, number one, it helps you as the evidence changes to change those guidelines. These are living, breathing things. And then also within a department, a department or group of physicians can use that to see the variability they even have. Physicians, we're pretty competitive, at the end of the day it's really no different than what we all do in pathology, where we go back and each one of us ... like in my group we had five pathologists, and somebody would go back and review every one of my frozen section diagnoses, and wouldn't I feel pretty badly if I were the only outlier that I was not reading?

Seriously, and I've seen that happen with groups, where they kind of go, "Wow. Well, doctors one, two, three and four transfusing at this level and seem to be doing okay. What's kind of wrong with me?" I think physicians are perfectly capable of doing that one their own. So, I think, just getting ... starting with the state of the science, and everybody understanding that it's far easier than to move, incorporate guidelines, merge them into CPOE, and then have a way to be able to go back and pull that data, and look at it. You're never going to be 100%, we know that, because we're not making widgets here.

Joe: Absolutely right, and I think from my perspective, what you just said, especially talking about once you're putting these things out that it comes with education, that it comes with "why" is so important, and I think that gets missed a lot, that we expect clinicians to just, without really having a background in transfusion medicine, I think that's one thing that a lot of

laboratorians in particular miss, that most physicians, I'm guessing you didn't get a whole lot of transfusion medicine education in medical school, I didn't, and most physicians don't have that background. We have to give them something to stand on to understand the why, and I think that's hugely important.

Carolyn: I mentioned this about nurses, too. Nurses, I have a friend of mine that used to say that in nursing school he spent more time learning how to make a bed than he did delivering a transfusion. I mean, we were being a little bit glib in that conversation, I'll admit, but he said, "We don't." And you know what? Our nurses, as primary transfusionists, accept the responsibility of that high-volume, high-risk activity, and the nurses also, by understanding the state of the science, it empowers them to perhaps question, "Why are we doing this transfusion?", or maybe why not, or while they are transfusing, "What am I watching for?" I think it's important that we all understand that literature. I think by giving that literature to our blood bank medical technologists, our clinical laboratory scientists they'll go, "Oh wow, I didn't know that." And then if we're all educated on the same evidence, then we talk better to each other, and that's what it's all about.

Joe: It is, and in the end, as you said, to kind bring this all back to where we started, it's all about keeping our patients safe. That's what we're trying to do, that's our whole entire goal.

Carolyn: Yeah. It's interesting because SABM's little byline on their website says, "Education, evidence, better patient outcomes."

Joe: Yep, absolutely. Well, Carolyn, this has been a fantastic conversation, and I think that you have ... Well, you've convinced me, and I hope that you've convinced some of the folks out there that it's not just a good idea to have a transfusion committee/PBM committee, in fact, let's just call it a PBM committee, I think that's a great goal for us to get towards. I think that you've given us a lot of good reasons to do this, a lot of why's, which I think is vitally important. So, thank you so very much for spending time with me.

Carolyn: Well, thanks, Joe, it's always a pleasure, and thanks for getting the message out about this, and I'm with you, I hope this helps, and some of the resources that you'll put up on the website I think would be really useful, so thanks.

Joe: Hi, everyone, it's Joe with just a couple of quick thoughts before I let you go.



I do want to mention again that this is a continuing education activity. So if you're a physician or a laboratorian, don't forget to visit wileyhealthlearning.com/transfusionnews to get your hour of totally free continuing education credit. Just a reminder, my thanks for that, as always, to Transfusion News, to Bio-Rad who brings you Transfusion News, as well as to Wiley Health Learning, of course.

So, I'm deciding where to go with the next episode of Blood Bank Guy Essentials, to be honest. Many of you have written to ask if I'll do an episode on COVID-19 convalescent plasma, and I will be making that decision soon. I have several other episodes, several other interviews that I have recorded prior to COVID, so we'll see what happens, but please check back soon.

But until next time, my friends, I hope that you smile, and have fun, (this is important), tell the ones that you love that you do, and above all, never ever stop learning. Thanks very much for listening. I'll catch you next time on the Blood Bank Guy Essentials Podcast.