Gynecologic Oncology Biannual Meeting

April 23, 2022

https://moqc.org

@MOQCTeam
Land Acknowledgement

https://native-land.ca/
Reminder – How to Mute

To mute your microphone

To unmute your microphone

*6 to mute/unmute

Just Kidding!!!
Join at slido.com #060 388
<table>
<thead>
<tr>
<th>TIME</th>
<th>TOPIC</th>
<th>FACILITATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00 am</td>
<td>Welcome &amp; Introductions</td>
<td>Vanessa Aron, BA</td>
</tr>
<tr>
<td>9:10 am</td>
<td>Patient &amp; Caregiver Oncology Quality Council (POQC) Update</td>
<td>Amanda Itliong, BA, MEd</td>
</tr>
<tr>
<td>9:20 am</td>
<td>Disparities Workshop</td>
<td>Vanessa Aron, BA</td>
</tr>
<tr>
<td>10:20 am</td>
<td>Data &amp; Updates</td>
<td>Shitanshu Uppal, MD</td>
</tr>
<tr>
<td></td>
<td>MOQC Performance &amp; Trends</td>
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<td></td>
<td>MSQC Performance &amp; Trends</td>
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<tr>
<td></td>
<td>VBR Measures &amp; Requirements</td>
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<tr>
<td></td>
<td>Opioid Calculator</td>
<td></td>
</tr>
<tr>
<td>11:15 am</td>
<td>Lunch</td>
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</tr>
<tr>
<td>11:45 am</td>
<td>Placenta Accreta</td>
<td>Michelle Debbink, MD, PhD Aimee Rolston, MD, MS</td>
</tr>
<tr>
<td>12:45 pm</td>
<td>Resources Overview and Closing</td>
<td>Vanessa Aron, BA</td>
</tr>
<tr>
<td>1:00 pm</td>
<td>Adjourn</td>
<td></td>
</tr>
</tbody>
</table>
Reminder – Information is Confidential
New Participation Agreements
Patient Story Idea?
Please email: moqc@moqc.org
Patient-Reported Outcomes

Leadership: Christopher R. Friese, PhD, RN

Biannual meeting panel presentation
Patient-Reported Outcomes (PROs)

The PROs Task Force is Active
Join us: moqc@moqc.org

- Establishing key principles
- Plan the panel presentation
- Open to everyone
  - Physicians, NPs, PAs, SWs
- Meets once a month
Testimonials

https://umich.qualtrics.com/jfe/form/SV_0Hzm2GOTxtcDoh0
POQC Update
Amanda Itliong, BA, MEd
Amanda Itliong, BA, MEd
POQC Workgroups

BVOGUE

Financial
Navigation

Recruitment

Patient & Caregiver
Resources

For questions and follow-up email moqc@moqc.org
Polls for Caregiving
<table>
<thead>
<tr>
<th>RECOMMENDATION</th>
<th>PRACTICE</th>
<th>RESEARCH</th>
<th>POLICY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendations to address structural inequities and social injustice</td>
<td></td>
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</tr>
<tr>
<td>• Address income and wealth inequality</td>
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<tr>
<td>• Support targeted provisions</td>
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<tr>
<td>• Support models of care that consider social risk</td>
<td></td>
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<tr>
<td>• Enhance multilevel research</td>
<td>•</td>
<td></td>
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<tr>
<td>• Implement focused training for health care providers</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Recommendations to address institutional environments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Improve access to high-quality care</td>
<td></td>
<td></td>
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<tr>
<td>• Enhance standards relevant to patients’ social circumstances</td>
<td></td>
<td>•</td>
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<tr>
<td>• Enhance navigation and service integration</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Recommendations to address living environments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Enhance surveillance data and data integration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Increase cross-sectoral collaboration</td>
<td></td>
<td></td>
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<tr>
<td>Cross-cutting recommendations</td>
<td></td>
<td></td>
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<tr>
<td>• At the leadership level, commit to eliminating disparities</td>
<td></td>
<td></td>
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<tr>
<td>• Proactively partner with disadvantaged communities/patients</td>
<td></td>
<td></td>
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<tr>
<td>• Consistently monitor progress and provide feedback</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Kassandra I. Alcaraz, PhD, MPH 1; Tracy L. Wiedt, MPH2; Elvan C. Daniels, MD, MPH3; K. Robin Yabroff, PhD4; Carmen E. Guerra, MD5; Richard C. Wender, MD2

CA A Cancer J Clinicians, Volume: 70, Issue: 1, Pages: 31-46, First published: 29 October 2019, DOI: (10.3322/caac.21586)
**Discuss with your table**

What quality improvement initiatives would fall into the scope of gynecologic oncologists to improve?

What kind of measure would we like to create centered around improving quality in the area of health disparities?

What information would we need to track that measure?

What data fields would be necessary to measure this?

---

**Measure Selection Strategy**

- Means something
- Feasible to measure
- Addresses variations in care
- Evidence-based
- Addresses gaps in care
- Advances care for patients/caregivers
- Sufficient numbers
- Part of the value equation
Measure Selection Strategy

- Means something
- Feasible to measure
- Addresses variations in care
- Evidence-based
- Addresses gaps in care
- Advances care for patients/caregivers
- Sufficient numbers
- Part of the value equation

Report Back

A suggested measure for MOQC to consider in the future

Why that measure links to an opportunity for quality improvement

Necessary elements to track that measure
Practices with no eligible cases in the denominator and/or missing data from one of the time periods are not shown.
## Participation Reminder to Qualify for VBR

<table>
<thead>
<tr>
<th>Level</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Practice Level</strong></td>
<td>At least <strong>one physician and one practice manager</strong> from the practice must attend <strong>both</strong> MOQC Gynecologic Oncology Biannual Meetings during that year</td>
</tr>
<tr>
<td><strong>Physician Level</strong></td>
<td>Provider must be enrolled in PGIP for at least one year</td>
</tr>
</tbody>
</table>
Practices with no eligible cases in the denominator and/or missing data from one of the time periods are not shown.
## MOQC Gynecologic Oncology Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>MOQC Pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td>CORE 10</td>
<td>Chemotherapy intent (curative vs non-curative) documented before or within 2 weeks after administration</td>
</tr>
<tr>
<td>SMT 28</td>
<td>NK1 receptor antagonist and olanzapine prescribed or administered with high emetic risk chemotherapy</td>
</tr>
<tr>
<td>MED #2</td>
<td>Complete family history document for patients with invasive cancer</td>
</tr>
<tr>
<td>MED #3</td>
<td>GCSF administered to patients who received chemotherapy for non-curative intent</td>
</tr>
<tr>
<td>EOL 42</td>
<td>Hospice enrollment</td>
</tr>
<tr>
<td>EOL 48</td>
<td>Chemotherapy administered within the last 2 weeks of life</td>
</tr>
<tr>
<td>Hospice_7 days</td>
<td>Enrolled in Hospice for over 7 days</td>
</tr>
<tr>
<td>Hospice_30 days</td>
<td>Enrolled in Hospice for over 30 days</td>
</tr>
<tr>
<td>GYN ONC 90g</td>
<td>Operative Report with Documentation of Residual Disease – 2021 VBR Measure</td>
</tr>
</tbody>
</table>
Chemotherapy Intent (Curative vs. Non-Curative) Documented before or within Two Weeks after Administration

N = 165
Carboplatin:
AUC ≥ 4 is HIGH
AUC < 4 is MODERATE
Carboplatin + Doxo is HIGH
Complete Family History Documented for Patients with Invasive Cancer
N = 114

Complete family history:
1\textsuperscript{st} & 2\textsuperscript{nd} degree relatives AND age at diagnosis
G-CSF Given with 1st Cycle Non-Curative Chemotherapy (Lower Score - Better)
N = 10

QOPI Measure Practice MED #3 - and Comparative Groups
Fall 2021
Chemotherapy Given within the Last 2 Weeks of Life (Lower Score - Better)  
N = 89
Hospice enrollment
N = 88

QOPI Measure Practice EOL 42 - and Comparative Groups
Fall 2021

Percent

<table>
<thead>
<tr>
<th>Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 (n=2)</td>
<td>0%</td>
</tr>
<tr>
<td>120 (n=1)</td>
<td>0%</td>
</tr>
<tr>
<td>100 (n=4)</td>
<td>25%</td>
</tr>
<tr>
<td>1000 (n=9)</td>
<td>44%</td>
</tr>
<tr>
<td>1001 (n=2)</td>
<td>50%</td>
</tr>
<tr>
<td>QOPI (n=1088)</td>
<td>57%</td>
</tr>
<tr>
<td>26 (n=12)</td>
<td>68%</td>
</tr>
<tr>
<td>50 (n=7)</td>
<td>71%</td>
</tr>
<tr>
<td>GYN (n=88)</td>
<td>74%</td>
</tr>
<tr>
<td>1002 (n=41)</td>
<td>95%</td>
</tr>
</tbody>
</table>
Enrolled in Hospice over 7 Days
N = 58

QOPI Measure Practice EOL_7days - and Comparative Groups
Fall 2021
Enrolled in Hospice over 30 Days
N = 58
MSQC Gynecologic Oncology Measures
## MSQC Gynecologic Oncology Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>MOQC Pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Emergency Room Utilization</td>
</tr>
<tr>
<td>2</td>
<td>Readmission Rates</td>
</tr>
<tr>
<td>3</td>
<td>Reoperation Rates</td>
</tr>
<tr>
<td>4</td>
<td>Serious Complications</td>
</tr>
<tr>
<td>5</td>
<td>Surgical Site Infections</td>
</tr>
<tr>
<td>6</td>
<td>Urinary Tract Infections</td>
</tr>
<tr>
<td>7</td>
<td>Venous Thromboembolism</td>
</tr>
</tbody>
</table>
Emergency Room Utilization

Gyn Onc Measure FLG_UTIL_ED - and Comparative Groups
Fall 2021

- Benign
- Cancer

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Benign</th>
<th>Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laparoscopic (n=46)</td>
<td>10.87%</td>
<td></td>
</tr>
<tr>
<td>Open (n=158)</td>
<td>6.33%</td>
<td></td>
</tr>
<tr>
<td>Robotic (n=261)</td>
<td>4.21%</td>
<td></td>
</tr>
<tr>
<td>Laparoscopic (n=95)</td>
<td>3.16%</td>
<td></td>
</tr>
<tr>
<td>Open (n=246)</td>
<td>6.91%</td>
<td></td>
</tr>
<tr>
<td>Robotic (n=486)</td>
<td>3.7%</td>
<td></td>
</tr>
</tbody>
</table>
Readmission Rates

Gyn Onc Measure FLG_UTIL_READM - and Comparative Groups
Fall 2021
Reoperation Rates

Gyn Onc Measure FLG_UTIL_REOP - and Comparative Groups
Fall 2021
Serious Complications

Gyn Onc Measure FLG_DASH_CMP_SERIOUS - and Comparative Groups
Fall 2021

- Benign
- Cancer

Percent

- Laparoscopic (n=46): 0.0%
- Open (n=158): 3.16%
- Robotic (n=261): 0.38%
- Laparoscopic (n=95): 0.0%
- Open (n=246): 1.63%
- Robotic (n=486): 1.23%
Surgical Site Infections

Percent

- SSI SERIOUS Benign
- SSI SERIOUS Cancer
- SSI Benign
- SSI Cancer

Gyn Onc Measure SSI and SSI SERIOUS - and Surgical Approaches Year 2021
Urinary Tract Infection

Gyn Onc Measure FLG_DASH_CMP_UTI - and Comparative Groups
Fall 2021
Venous Thromboembolism

Gyn Onc Measure FLG_DASH_CMP_VTE - and Comparative Groups
Fall 2021

- Benign
- Cancer

<table>
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</table>
Fee Schedule Increase Opportunities
# 2022 Fee Schedule Increase Summary

## Tobacco Cessation Opportunity

<table>
<thead>
<tr>
<th>Collaborative-Wide (with Med Onc) - Meet 2 of 3</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Proportion of patients with smoking status recorded</td>
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**2% Opportunity**

## VBR Measure Opportunity

<table>
<thead>
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<tr>
<td>Days from debulking surgery to chemotherapy start</td>
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**3% Opportunity**

## Race/Ethnicity Data Opportunity

<table>
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<tr>
<th>Practice Meet Both</th>
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<tr>
<td>Meet VBR measures</td>
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<tr>
<td>Race and ethnicity data documented in the oncology record</td>
</tr>
</tbody>
</table>

**Additional 2% Opportunity**

---

**Total eligibility: up to 7%**
Tobacco Cessation Opportunity
Keli DeVries, LMSW
## Tobacco Cessation Opportunity

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</table>

**Additional 2% Opportunity**

---

**Total eligibility: up to 7%**
CORE 22bb: Tobacco cessation counseling administered or patient referred in the past year

- MOQC Performance
- MDHHS Data
- VBR Target

p < 0.001

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>33%</td>
<td>44%</td>
<td>52%</td>
<td>56%</td>
<td>64%</td>
<td>73%</td>
<td>65%</td>
<td>64%</td>
</tr>
</tbody>
</table>
Continued smoking after ovarian cancer diagnosis can increase mortality rates by 40%.

Never smokers and individuals quitting after diagnosis show comparable survival rates.

Women who are current smokers are 21% more likely to die from cervical cancer. 

And 35% more likely to die of any cause compared with known non smoking cases.

Quitting smoking during cancer treatment can…

- Improve the effectiveness of chemotherapy
- Decrease the risk of complications and serious side effects
- Increase survival rates for tobacco-related and non-tobacco related cancers
Tobacco Cessation Measure #1

- Tobacco cessation counseling given or patient referred in the past year (Target: 75%)

**Examples of chart documentation that meet this measure:**

- Reviewed ASCO NSCLC booklet on Smoking Cessation. Provided quit kit and fidgets to patient at this time.
- Informed patient on quitSTART app
- Provided a brochure from the local support group offering smoking cessation meetings
- Patient referred to QuitLine
Tobacco Cessation - Measure #2

- Proportion of patients with smoking status recorded (Target: 90%)

Examples of chart documentation that meet this measure:

- Current Smoker. Strongly encouraged to quit smoking.
- Current Smoker. Advised to quit. Patient declined referral to Tobacco Quitline.
- Former smoker. Pt quit smoking in 2015.
Tobacco Cessation - Measure #3

- Proportion of patients with smoking treatment recorded (Target: 30%)

Examples of chart documentation that meet this measure:

- PCP prescribed Chantix to patient (in the oncologist’s note).
- Discussed Bupropion with pt. Sent a prescription to the preferred pharmacy.
- Nicotine patch prescribed to patient.
VBR Measures
Shitanshu Uppal, MD
### Tobacco Cessation Opportunity

<table>
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**2% Opportunity**

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**3% Opportunity**

### Race/Ethnicity Data Opportunity

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</tr>
</tbody>
</table>

**Additional 2% Opportunity**

**Total eligibility: up to 7%**
Days between Cytoreduction and 1st Day of Chemotherapy
N = 82

VBR Target 28 days
Morphine Equivalents

Gyn Onc Measure Opioids Prescription - and Surgical Approaches Year 2021
Oxycodone

Gyn Onc Measure Oxycodone 5 mg Prescription - and Surgical Approaches Year 2021
- Include criteria: patient who received cryosurgery for malignancy

- Preoperative compliance: Ask preoperatively: How is the patient doing? Are there any concerns? How long have they been doing this procedure?

- Cryosurgery parameters: Prior to starting having more than 3 pills remaining after 30 days
Questions?
Race & Ethnicity Data Opportunity
Keli DeVries, LMSW
# 2022 Value-Based Reimbursement Summary

## Tobacco Cessation Opportunity

<table>
<thead>
<tr>
<th>Collaborative-Wide (with Med Onc) - Meet 2 of 3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco cessation counseling administered or patient referred in the past year</td>
<td>75%</td>
</tr>
<tr>
<td>Proportion of patients with smoking status recorded</td>
<td>90%</td>
</tr>
<tr>
<td>Proportion of patients with smoking treatment recorded</td>
<td>30%</td>
</tr>
</tbody>
</table>

### 2% Opportunity

## VBR Measure Opportunity

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Days from debulking surgery to chemotherapy start</td>
<td>28 days</td>
</tr>
<tr>
<td>Outpatient prescribing of opioids for cancer patients after laparoscopic or open hysterectomy</td>
<td>9 pills</td>
</tr>
</tbody>
</table>

### 3% Opportunity

## Race/Ethnicity Data Opportunity

<table>
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<tr>
<th>Practice Meet Both</th>
<th></th>
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<tbody>
<tr>
<td>Meet VBR measures</td>
<td>2</td>
</tr>
<tr>
<td>Race and ethnicity data documented in the oncology record</td>
<td>90%</td>
</tr>
</tbody>
</table>

### Additional 2% Opportunity

## Total eligibility: up to 7%

---

66
Completeness of Race and Ethnicity Data
N = 256

MOQC Measure Demographics Completeness - and Comparative Groups
Fall 2021

VBR Target 90%

96% 98% 100% 100% 100% 100% 100% 100% 100% 100%

85% 67% 50% 26% 2% 49% 20% 120% 104% 109% 1001% 1002%

100 (n=6) 1005 (n=57) GYN (n=256) 26 (n=48) 2 (n=20) 49 (n=2) 20 (n=12) 120 (n=13) 104 (n=11) 109 (n=13) 1001 (n=6) 1002 (n=21)
Discussion
LUNCH!
Michelle Debbink, MD, PhD
Maternal-Fetal Medicine Specialist
University of Utah Health

Aimee Rolston, MD, MS
Gynecologic Oncology Fellow
Michigan Medicine

Placenta Accreta
Multidisciplinary management of Placenta Accreta Spectrum

A TALE OF TWO SISTERS
Conflict of Interest & Financial Disclosures

● We have no conflicts to disclose

● Michelle Debbink receives salary support from the March of Dimes and the American Board of Obstetrics and Gynecology as part of the Reproductive Scientist Development Program
Outline

● Background
● Multidisciplinary protocol
  ○ Preoperative
  ○ Intraoperative
  ○ Postoperative
● Future Directions/“Wish List”
Background

- **Placenta accreta spectrum (PAS)**
  - Abnormal adherence of trophoblasts to myometrium

- **Increasing incidence**
  - 1:4000 (1970s)
  - 1:500-700

---

![Graph showing incidence of unplanned hysterectomy and related conditions](image-url)
Placenta Accreta Spectrum Disorder
Uterine Dehiscence, Not Placental Invasion

Brett D. Einerson, MD, MPH, Jessica Comstock, MD, Robert M. Silver, MD, D. Ware Branch, MD, Paula J. Woodward, MD, and Anne Kennedy, MD
Background: Mortality

![Figure 1](image)

**Fig. 1.** Cause-specific mortality ratios (deaths/100,000 live births) and 95% CIs among females during pregnancy and up to 42 days from the end of pregnancy, United States, 2018–2019 (obstetric causes of death are World Health Organization ICD-10 underlying cause of death code group categories for direct maternal deaths\textsuperscript{18}).

Background: Morbidity

- Hemorrhage/massive transfusion
- Cystotomy/bladder repair
- Ureteral injury
- Bowel injury/obstruction
- ICU admission

Post-op
- VTE
- Pneumonia
- ARDS
- Pyelonephritis
- Prolonged catheterization
- Surgical site infection
- Fistula

Reoperation
GYO Involvement

**Graph:**
- **Years:** 2014 to 2021
- **Y-axis:** Number of cases
- **X-axis:** Gynecologic Oncologist as a primary surgeon
- **Legend:**
  - **Blue:** No
  - **Red:** Yes
- **Percentages:**
  - 2014: 33%
  - 2015: 33%
  - 2016: 33%
  - 2017: 33%
  - 2018: 33%
  - 2019: 80%
  - 2020: 80%
  - 2021: 80%
Multidisciplinary standardized approach = improved outcomes

Key Principles

1. The risk of placenta accreta spectrum (PAS) is highest in women with a history of prior cesarean and current placenta previa; PAS risk increases with each subsequent cesarean.

2. Ultrasound is the preferred tool for diagnosis of PAS.

3. The best outcomes occur with advanced planning for birth in a level III or IV center experienced in the care of women with PAS with a team of surgeons skilled in complex pelvic surgery, a full array of surgical sub-specialty consultants, obstetric anesthesiologists, interventional radiologists and a high-capacity blood bank proficient with massive transfusions.

4. Delivery is advised prior to the onset of labor.

5. ACOG suggests that infants of women with placenta previa with suspected accreta spectrum be delivered between 34 0/7-35 6/7 weeks gestation.

6. Counseling should be offered for those patients with PAS to address emotional concerns and trauma associated with their birth experience to mitigate poor mental health outcomes and increase healing and recovery.

Shamshirsaz et al 2015. AJOG
Institutional Context: Michigan

COVID-19 induced blood shortages
Routine REBOA access
Database creation and utilization

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<tr>
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## Institutional Approach: Michigan

### CLASSIFICATION SYSTEM

<table>
<thead>
<tr>
<th>Class</th>
<th>Description</th>
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<tbody>
<tr>
<td>Class I</td>
<td>Planned C-section; hysterectomy unlikely</td>
</tr>
<tr>
<td>Class II</td>
<td>Planned cesarean hysterectomy. Sub-classified based on suspicion for bladder/parametrial involvement:</td>
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<tr>
<td></td>
<td>IIA – low suspicion</td>
</tr>
<tr>
<td></td>
<td>IIB – indeterminate</td>
</tr>
<tr>
<td></td>
<td>IIC – high</td>
</tr>
<tr>
<td>Class III</td>
<td>Unplanned cesarean hysterectomy</td>
</tr>
<tr>
<td></td>
<td>IIIA – hemodynamically stable</td>
</tr>
<tr>
<td></td>
<td>IIIB – hemodynamically unstable</td>
</tr>
</tbody>
</table>

- 34-36 wk delivery
- GYN ORs; dedicated scrub team / nurses
- Gyn Onc and Acute Care Surgery at all cases
- Femoral A-line access for possible REBOA*
Institutional Context: **Utah**

- Placenta Accreta Call Team (MFM/OB/GYO)
- Routine Ureteral Stenting

**Multidisciplinary Placenta Accreta Planning Meeting**

- 2014: 6 cases
- 2015-19: 13, 15, 11, 12, 7 cases
- 2020: 11 cases
- 2021: 19 cases

- 2014: 15 cases
- 2015: 13 cases
- 2016: 7 cases
- 2017: 11 cases
- 2018: 12 cases
- 2019: 11 cases
- 2020: 15 cases
- 2021: 13 cases
### Classification System

<table>
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</tbody>
</table>

- 34-36 wk delivery
- Main/GYN ORs
- MFM Primary For Class I and Class IIA; GYO on backup
- Class IIB and above GYO present at start of case
- Trauma Surgery involvement for REBOA if Class IIC or Class IIIB
Multidisciplinary Protocols
Preoperative

**MICHIGAN**

- Imaging/Diagnosis – no routine MRI
- OR timing and planning
- Treat anemia aggressively
- Multidisciplinary Communication
  - Case class, specific personnel decided
  - Group email
  - EMR report
- Consults/Counseling
  - MFM
  - Anesthesia
  - NICU
  - Gyn Onc*
- Social Work
- Informational Materials
Preoperative

**MICHIGAN**
- Imaging/Diagnosis – no routine MRI
- OR timing and planning
- Treat anemia aggressively
- Multidisciplinary Communication
  - Case class, specific personnel decided
  - Group email
  - EMR report
- Consults/Counseling
  - MFM
  - Anesthesia
  - NICU
  - Gyn Onc*
- Social Work
- Informational Materials

**UTAH**
- Imaging/Diagnosis – no routine MRI
- Treat anemia aggressively
- Multidisciplinary Conference (modeled on tumor board)
  - Case class, who to involve
  - IR, REBOA, GYO, Anesthesia, Research
- Common for rural patients to be admitted/relocate
- Multidisciplinary Communication
  - Group email, specific personnel decided
  - EMR report
- Consults/Counseling
  - MFM
  - NICU
- Informational Materials
Intraoperative: Michigan

- Patient arrives to OR
- Pre-induction timeout
  - Key stakeholders
  - Review plan (cell saver, antibiotics, VTE prophylaxis)
  - Confirm presence of equipment, blood
- General anesthesia, access
- Patient prepped and draped
- Lines including femoral A-line
  - 5 Fr to start in most cases
- Pre-incision robust timeout
- Cesarean delivery
- Placental timeout*
  - Confirm if proceeding with hysterectomy
  - Confirm REBOA use
- Hysterectomy
- ROTEM
  - Directed resuscitation
REBOA
Resuscitative Endovascular Balloon Occlusion of the Aorta
REBOA

- Potential benefits
  - Decreased blood loss/# of transfusions

- Potential complications
  - Arterial thrombosis
  - Pseudoaneurysm
  - Nerve ischemia
  - Mesenteric ischemia
  - Limb ischemia
REBOA

● UM usage started in 2019
  ■ 2019 – 1/19 (<1%)
  ■ 2020 – 6/21 (29%)
  ■ 2021 – 3/16 (19%)*

*1st half of 2021

● 1 arterial thrombus → femoral arterial stent + anticoagulation
● 1 pseudoaneurysm → IR thrombin injection
Intraoperative: UTAH

- Patient arrives to OR
- Pre-induction robust timeout
  - Key stakeholders
  - Review plan (cell saver, antibiotics, VTE prophylaxis)
  - Confirm presence of equipment, blood

- Neuraxial analgesia
  - +/- Albumin
  - Radial arterial line
  - Cystoscopy with stents

- Cesarean delivery with stapler
- Confirm if proceeding with hysterectomy, robust team check in
- Conversion to GETA
- Hysterectomy (protocolized approach)
- Routine: oxytocin, TXA, ROTEM
  - Directed resuscitation
- Intraoperative: UTAH
- Patient arrives to OR
- Pre-induction robust timeout
  - Key stakeholders
  - Review plan (cell saver, antibiotics, VTE prophylaxis)
  - Confirm presence of equipment, blood

- Neuraxial analgesia
  - +/- Albumin
  - Radial arterial line
  - Cystoscopy with stents
Ureteral Stenting

<table>
<thead>
<tr>
<th>Primary Outcome</th>
<th>Primary Outcome (without intentional cystototomy)</th>
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<tbody>
<tr>
<td>Unadjusted</td>
<td>0.37 (0.21, 0.65)</td>
</tr>
<tr>
<td>Adjusted 1</td>
<td>0.27 (0.14, 0.52)</td>
</tr>
<tr>
<td>Adjusted 2</td>
<td>0.21 (0.10, 0.43)</td>
</tr>
<tr>
<td></td>
<td>0.36 (0.17, 0.76)</td>
</tr>
</tbody>
</table>

Adjusted for: urgency of delivery, 3+ cesarean deliveries, whether a gynecologic oncologist was primary surgeon (Model 1) and adding disease severity (Model 1)
Postoperative

**MICHIGAN**
- Enhanced recovery protocols
  - Avoid PCA
  - Strict foley management
- Post REBOA monitoring, if used
- ICU admission NOT routine
- Lactation initiation

**UTAH**
- Universal post-op TAPS Block
- Enhanced recovery protocols
  - Avoid PCA
  - Strict Foley management
- ICU admission NOT routine
- Lactation initiation
ICU admission data

- 2014 – 2021 – University of Utah
  - Post op ICU admission decreased from 30-50% on average to 18-20% on average

- 2014-2021 – University of Michigan
  - Post op ICU admission decreased from 58% (2014-2019) to 35% (2020-2021)
Ripple Effect

- Bonding/NICU visits
- Trauma reduction
- Home sooner to family
- Lactation
- Reduction in trips back to hospital
Future directions

- Rural “alert bracelet”
- PTSD and emotional counseling/support groups from the start
- Streamlining these protocols for unplanned/emergent cases
- Developing protocols accessible to the community
  - How to stabilize and transfer
  - Who to call for help
Thank you!
Multidisciplinary management of Placenta Accreta Spectrum

A TALE OF TWO SISTERS
## Results: Case Series

<table>
<thead>
<tr>
<th>INTRAOPERATIVE COMPLICATIONS</th>
<th>n (%)</th>
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<tbody>
<tr>
<td>Bladder injury</td>
<td>8 (7.3%)</td>
</tr>
<tr>
<td>Ureter injury</td>
<td>4 (3.7%)</td>
</tr>
<tr>
<td>Vascular injury</td>
<td>3 (2.8%)</td>
</tr>
<tr>
<td>Femoral pseudoaneurysm</td>
<td>1 (0.9%)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>POSTOPERATIVE COMPLICATIONS</th>
<th>n (%)</th>
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</thead>
<tbody>
<tr>
<td>Surgical Site Infection</td>
<td>13 (11.2%)</td>
</tr>
<tr>
<td>Urinary tract Infection</td>
<td>11 (10.1%)</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>5 (4.6%)</td>
</tr>
<tr>
<td>Nerve injury</td>
<td>1 (0.9%)</td>
</tr>
</tbody>
</table>
Resources Overview and Closing
Vanessa Aron, BA
Resources

GYNECOLOGIC ONCOLOGY
- Gyn Onc Educational Series
- Ovarian Cancer Resources
- Past Meeting Library
- Standardized Op Note
- VTE Khorana Calculator
- VTE Prophylaxis Calculator

MOQC
- Becoming a MOQC Practice
- VBR: Value-Based Reimbursement
- Past Meeting Library
- Printed Resources

Educational Materials
Ovarian Cancer Checklists:
For Patients
For Physicians

Educational Videos:
Ovarian Cancer: Side Effects of Chemotherapy

Ovarian Cancer Education Podcasts
- Featured podcast:
  - Ovarian Cancer Education Podcast
    - Chemotherapy, Part 1
    - 9/17/2021 - 27 min • Listen later
  - Ovarian Cancer Education Podcast
    - Chemotherapy, Part 2
    - 9/17/2021 - 33 min • Listen later

Additional podcasts:
- Season 1, Ep. 3: Chemotherapy, Part 2
- Season 1, Ep. 3: Chemotherapy, Part 1
- Season 1, Ep. 2: Treatment Options
- Season 1, Ep. 1: New Diagnosis

Newsletter:
If you are interested in hearing about podcast episodes as they are released, sign up for our newsletter.
Ovarian Cancer Education Podcasts

Featured podcast:

- Ovarian Cancer Education Podcast
  - Chemotherapy, Part 1
  - 9/17/2021 • 27 min • Listen later

Additional podcasts:

- Season 1, Ep. 3: Chemotherapy, Part 2
- Season 1, Ep. 3: Chemotherapy, Part 1
- Season 1, Ep. 2: Treatment Options
- Season 1, Ep. 1: New Diagnosis

www.ovariancancerpodcast.com
MOQC Tobacco Cessation Resources

Resources

National Guidelines
- ASCO: Tobacco Cessation Guide
- NCCN: Smoking Cessation Guidelines

National Reports
- Surgeon General: The Health Consequences of Smoking – 50 years of Progress
- Surgeon General: E-Cigarette Use Among Youths and Young Adults

Michigan Programs
- Michigan Tobacco Quitline
  - Michigan Tobacco Quitline FAQs
  - Quitline Insurance Eligibility
- Blue Cross Blue Shield of Michigan

MOQC Michigan Tobacco Quitline video:
If you are a MOQC member and would like a copy of this video, which you can upload to devices at your practice, please contact moqc@moqc.org

Michigan Tobacco Quitline Resources
- Call center available 24/7
- Nicotine Replacement Therapy (gum or patches)
- Coaching sessions
- Email, text, or chat support

Watch on YouTube
Tobacco Cessation Resources

HBOM has curated a selection of state and national tobacco cessation resources. Click on an individual resource to find more information on what they offer and how to access services.
Available Now!

Tobacco Cessation Resources

• HBOM is developing materials to support counseling and referral, including...
  • Patient and provider tools for cessation
    • Counseling and prescription guidelines
  • “One-tap” referral cards
  • MI Tobacco Quitline patient information cards

www.hbomich.org/box-request
MOQC has a variety of free resources for your patients, caregivers and practice sites in both virtual and printed formats.

Visit [https://www.moqc.org/resources/](https://www.moqc.org/resources/)

**Cancer, Thriving, and Surviving Workshops**

**Friday Morning Series:**
Apr. 15 – May 20, 2022
10:00 am - 12:30 pm

**Tuesday Afternoon Series:**
May 24 – June 28, 2022
2:00 pm - 4:30 pm

2022 MOQC June Biannual Meeting Information

June 17, 2022
10:00am - 4:00pm
(Registration at 9:00am, program starts at 10:00am)
Radisson Hotel Lansing at the Capitol
Lansing, MI

Multidisciplinary PROs Panel
Led by Christopher Frise, PhD, RN, Director of Patient-Reported Outcomes

The Clinician as Activist
Interview with Jerome Seid, MD

Discussion on the Importance of Caregivers
Featured Presenter: Laurel Northouse, PhD, RN, FAAN

Register NOW:  https://moqc.org/events/
October 1, 2022
Time: TBD
Michigan League
911 N University Ave.
Ann Arbor, MI 48109

In partnership with the Heartland Association of Gynecologic Oncology (HAGO)
# Continuing Education Credits

<table>
<thead>
<tr>
<th>Group</th>
<th>Number of Credits</th>
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<tbody>
<tr>
<td>Physician/Nurse</td>
<td>3.5</td>
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Steps to create a MiCME Account:
1. Go to https://ww2.highmarksce.com/micme/
2. Click the “Create a MiCME Account” tile at the bottom of the screen
3. Under New User? click “Create a MiCME Account”
4. Enter the Profile Information questions, confirm consent, and click “Create a MiCME Account”
5. Enter your password and complete your profile. Your MiCME account is created, and you can now claim continuing education credits.

Steps to Claim Credits and Print a Transcript
1. Once your MiCME account has been created, navigate to your Dashboard
2. Click on Claim Credits and View Certificates
3. Locate ‘MOQC Gynecology Oncology Spring 2022 Meeting’ in the Activities Available for Credit Claiming section
4. Under Action, click on Claim. Add Credit.
5. Enter the number of credits you are claiming and the “I Attest” button.
6. Complete the evaluation.
7. Click the Submit button.
8. Scroll down to the Awarded Credits section to view or print your certificate and/or comprehensive University of Michigan CME transcript.
9. Social Work: A certificate will be e-mailed to you

If you have any difficulties, email moqc@moqc.org We will be happy to assist you!
Thank You