MOQC

MICHIGAN ONCOLOGY QUALITY CONSORTIUM

JUNE BIANNUAL

2026

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MICHIGAN ONCOLOGY QUALITY CONSORTIUM

Welcome

Keli DeVries, LMSW

Core Values

Trust & Integrity

- Our transparency and openness build psychological safety. We communicate when things change and we are accountable to one another and to our purpose.

Compassion

- We honor each person’s dignity and well-being with empathy and care.

Growth Mindset

- We are flexible, discerning, and open to challenges and different ideas. We continually evaluate, adapt, and innovate.

Collaboration

- We do our best work together, creating an environment of mutual empowerment.

Agenda - Morning

- 10:00AM Welcome & Opening
- 10:15AM Steering Committee Update
- 10:20AM Voices of Patients & Caregivers
- 10:30AM Faith & Culture Panel
- 12:00PM Lunch & Resource Fair

Agenda - Afternoon

- 1:15PM YesRx
- 1:20PM POQC Update
- 1:30PM Pharmacogenetics Panel
- 2:30PM Break
- 2:40PM Palliative Care Update
- 2:50PM MEQC Celebration
- 3:00PM Performance Measures

Confidentiality

Taking pictures or videos of data slides, including the use of AI bots to record, is prohibited. This is a confidential professional peer review and quality assurance document of the Michigan Oncology Quality Consortium.

Unauthorized disclosure or duplication is absolutely prohibited. It is protected from disclosure pursuant to the provisions of Michigan Statutes MCL 333.20175; MCL 333.21513; MCL 333.21515; MCL 331.531; MCL 331.532; MCL.331.533 or such other statutes as may be applicable.

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Disclosure Statement

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In support of improving patient care, this activity is planned and implemented by The National Center for Interprofessional Practice and Education Office of Interprofessional Continuing Professional Development (OICPD) and the Michigan Oncology Quality Consortium. The National Center OICPD is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

Physicians: The National Center OICPD designates this activity for a maximum of **4** *AMA PRA Category 1 Credit(s)*™. Physicians should only claim credit commensurate with their participation.

Nurses: Participants will be awarded up to **4** contact hours of credit for attendance at this activity.

Nurse Practitioners: The American Academy of Nurse Practitioners Certification Program (AANPCP) accepts credit from organizations accredited by the ACCME and ANCC.

Pharmacists and Pharmacy Technicians: This activity is approved for **4** contact hours (.4 CEU)

Social Workers: As a Jointly Accredited Organization, the National Center OICPD is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. The National Center OICPD maintains responsibility for this course. Social workers completing this course receive up to **4** continuing education credits.

IPCE CREDIT™

IPCE: This activity was planned by and for the healthcare team, and learners will receive **4** Interprofessional Continuing Education (IPCE) credits for learning and change

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Interprofessional Development

Completed two successful IPD series

Caregiver Navigation

Advance Care Planning

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Oncology Stewardship Initiative to Improve Biomarker Testing in mNSCLC

On-demand video modules are now available

Module 1: Navigating Modalities and Multidisciplinary Decision Making

Available on June 30!

Module 2: Target to Treatment: Applying a stewardship lens to frontline therapies in oncology

https://www.pharmacytimes.org/pages/nsclc-resource-center-moqc

IPD Opportunity

Watch and discuss Module 1 with peers across the state

Biomarker -Driven Decisions in NSCLC

July 23, 2026
12:00 -1:30 pm
Virtual

Register now

Ideal for APPs, RNs, pharmacists, MDs

Oncology Stewardship

Educational resources coming soon

- Short videos for patients explaining biomarker testing for NSCLC
- Visual representation: What is Oncology Stewardship?

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Access & Outcomes Advisory Committee

Strategic Plan 2025-2027

Community Engagement

- Enhancing Community Engagement in Cancer Care

Access to Resources

- Improving Resources Supporting Accessibility of Cancer Care

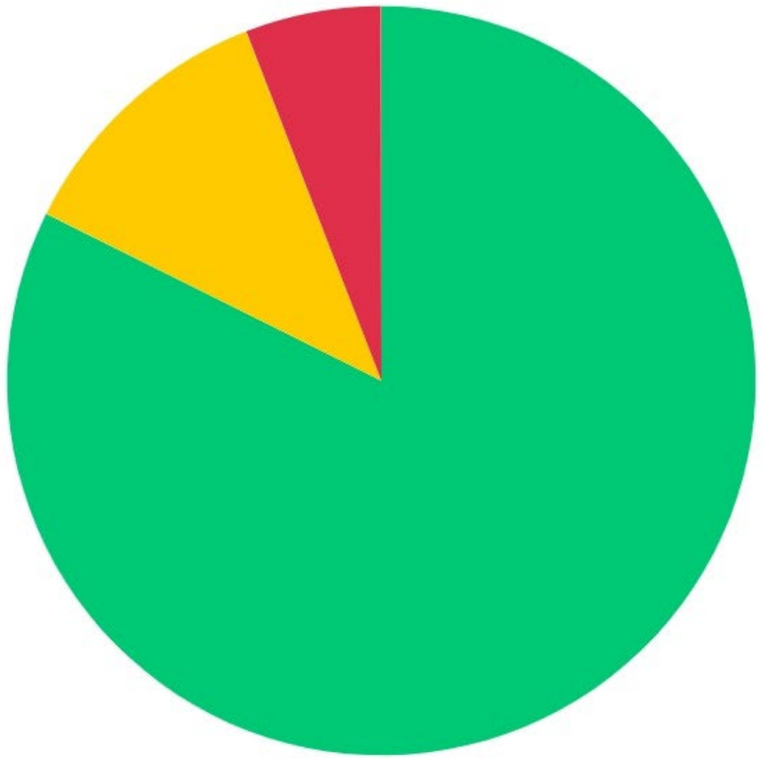
Data

- Measuring and Analyzing Cancer Care

Collaboration

- Building Collaboration Among Cancer Care Teams and Organizations

2025 Progress



N = 17 objectives

Maintained or Improved: 82.4% No Activity: 11.8% Declined: 5.9%

Priorities for 2026

1. Develop **relationships with community groups** to identify community needs, share resources, etc.

2. Explore the creation of a **resource sharing hub**, allowing practices to give and receive resources to patients in need

Access & Outcomes Advisory Committee Members

Lydia Benitez Colon, PharmD, BCOP
Michigan Medicine

Tracey Cargilll-Smith, POQC

Michael Dudley, POQC

Suzanne Fadly, PharmD
KCI at McLaren Greater Lansing

Zachary Hector-Word, MD
Munson Healthcare

Yelena Kier, DO
Munson Healthcare

Iman Mohamed, MD
Ascension Borgess

Jeanie Mullen
Memorial Healthcare Cancer Center

Erin Plunkett
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Henry Ford Health

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Angela Hospice

Elena Stoffel, MD, MPH
Michigan Medicine

Carmen Stokes, PhD, CNE
Henry Ford Health

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Steering Committee Report

Dawn Severson, MD

Steering Committee Members

Savitha Balaraman, MD
MHP Oakland Medical Group

Kevin Brader, MD
University of Michigan Health-West

Tracey Cargill-Smith, POQC

Tammy Cedo, POQC

Tim Cox, MD
Bronson Cancer Center

Diane Drago, POQC

Nick Erikson, MBA
Trinity Health

Jayson Field, MD
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Sherry Levandowski, MD
MyMichigan Health

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Great Lakes Cancer Management Specialists

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MOQC Abstractor

Dawn Severson, MD
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Beth Sieloff, MPH, RYT-200
Inter-Tribal Council of Michigan

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Michael Stellini, MD, MS
Karmanos Cancer Center

Carmen Stokes, PhD, CNE
Henry Ford Health

Ammar Sukari, MD
Karmanos Cancer Institute

Padmaja Venuturumilli, MD
Hematology Oncology Consultants

Shannon Wills-Velez, PhD, MS, PA-C
Henry Ford Health

Steering Committee

MSTCVS survey coming soon

Investigating strategies to engage senior leadership

VBR Scorecard coming your way!

VBR Scorecard
Michigan Oncology Quality Consortium

VBR Measurement Period (unless specified otherwise):
11/01/2026 - 10/31/2027
VBR Payout - 2028

Measure #	Measure Description	Points
1	**Performance Measure 108a:** Complete family history documented for patients with invasive cancer **Measurement level: Practice**	
	>= 40% and >= 20 patients in the denominator	16
	>= 30% and < 40% and >= 20 patients in the denominator **OR** >= 40% and < 20 patients in denominator	8
	< 30% **OR** >= 30% and < 40% and < 20 patients in the denominator	0
2	**Performance Measure 115:** Olanzapine prescribed as part of a 4-drug antiemetic regimen with cycle 1 high emetic risk chemotherapy **Measurement level: Practice**	
	>= 65% and >= 20 patients in the denominator	16
	>= 50% and < 65% and >= 20 patients in the denominator **OR** >= 65% and < 20 patients in denominator	8
	< 50%	0
3	**Performance Measure126a:** Hospice enrollment **Measurement level: Region**	
	>= 65%	16
	>= 50% and < 65%	8
	<50%	0
4	**Performance Measure 126d:** Median days on hospice **Measurement level: Region**	
	>= 11 days	16
	>= 8 days and <11 days	8
	< 8 days	0
5	**Performance Measure 129:** Palliative care consultation more than 90 days before death **Measurement level: Region**	
	>= 25%	16
	>= 19% and <25%	8
	<19%	0
6	**Performance Measure 101b:** Tobacco cessation counseling or referral for tobacco users once a year **Measurement level: Collaborative-wide**	
	>= 68%	20
	>= 51% and <68%	10
	<51%	0
	Total Points Possible	100

VBR Eligibility Scale	Points Threshold
Points Threshold to Meet 102% VBR eligibility	>= 40-51
Points Threshold to Meet 103% VBR eligibility	>= 52-63
Points Threshold to Meet 104% VBR Eligibility	>= 64-75
Points Threshold to Meet 105% VBR eligibility	>= 76-87
Points Threshold to Meet 107% VBR eligibility	>= 88-100

Join Us

Measures Committee

July 7, 5 - 7pm

Steering Committee

July 21, 5 - 7pm

Email moqc@moqc.org for details

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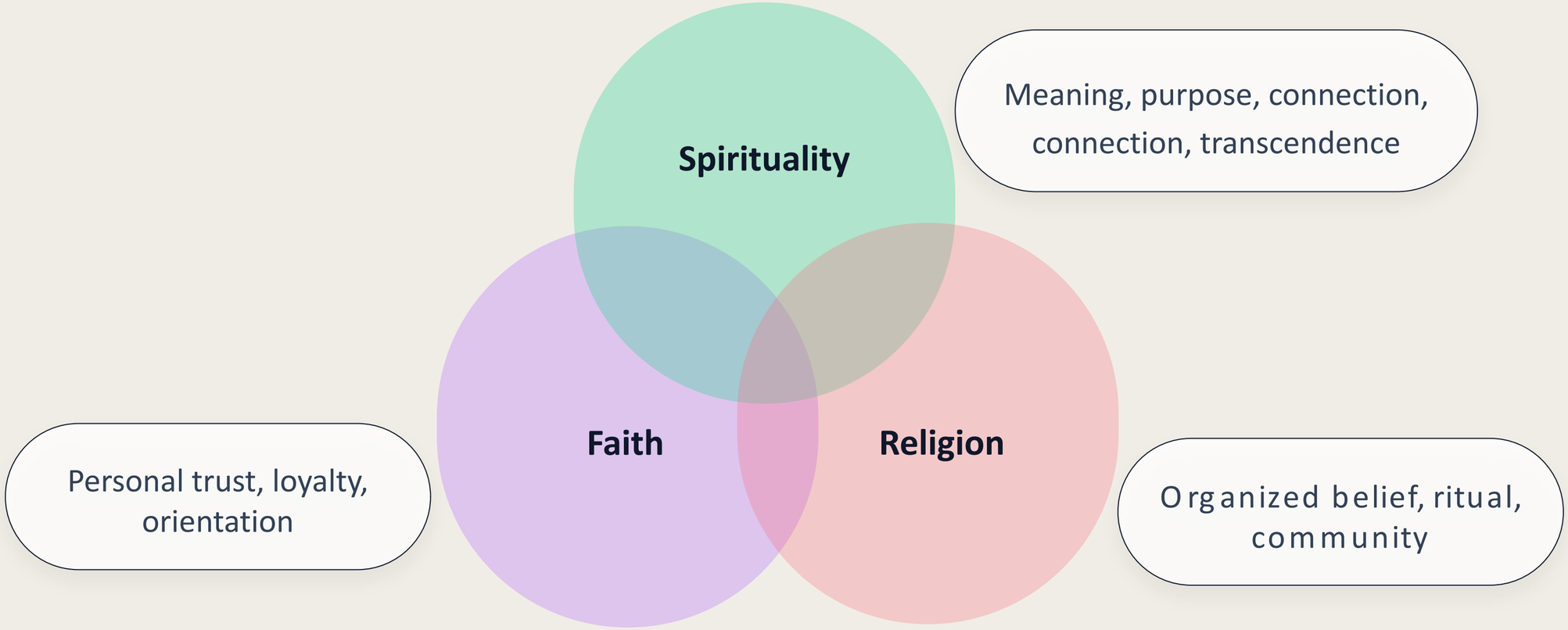
Voices of Patients & Caregivers

Culture

Shared values, meanings, norms, and practices that shape how groups live, interpret illness, and organize care.



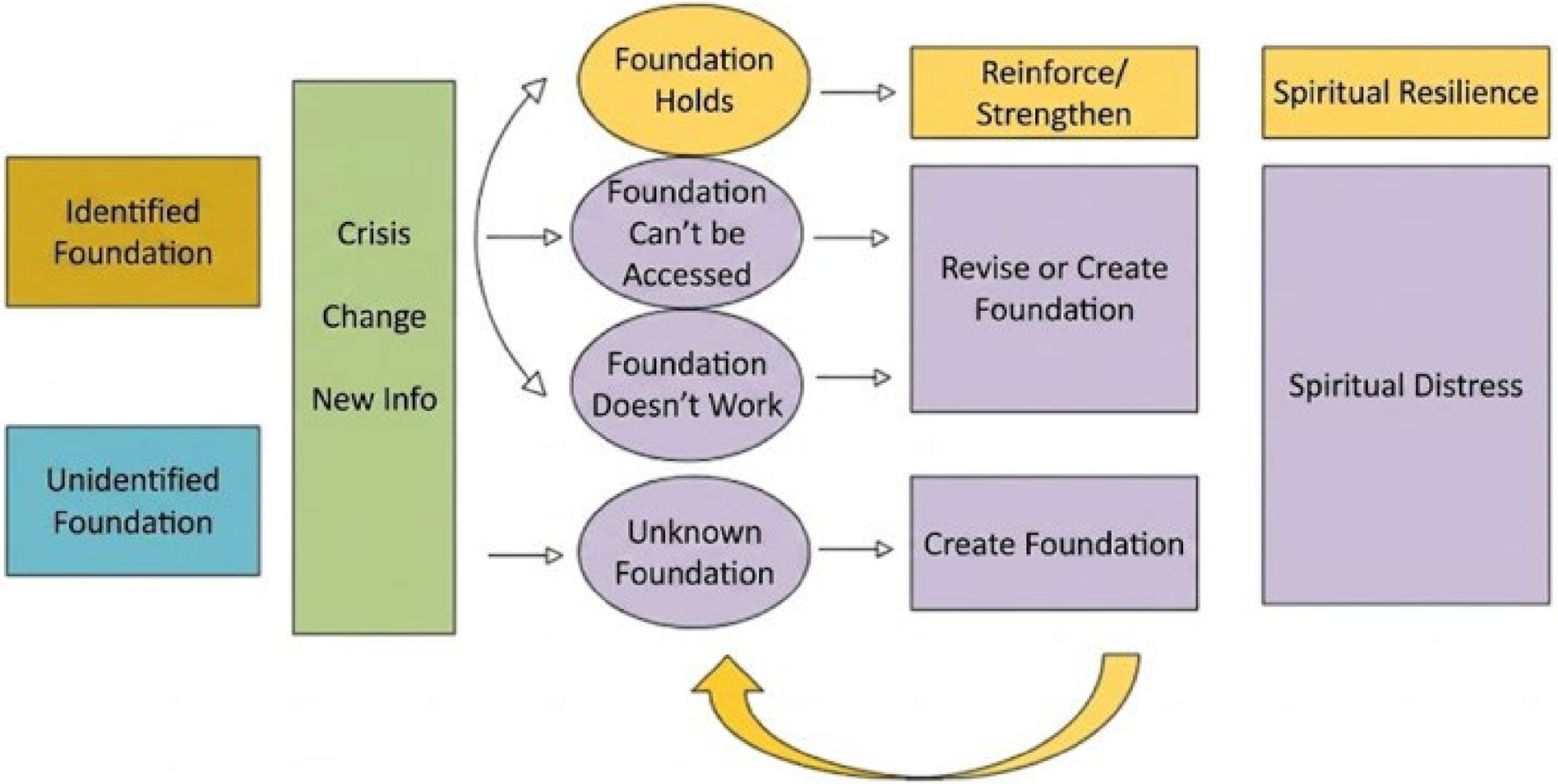
Intersection of Faith, Religion, Spirituality & Culture

Rev. Christina L. Wright, PhD

Associate Director

Department of Spiritual Care; Michigan Medicine

christlw@med.umich.edu



Origins of Spiritual Distress

When facing challenges, one's regular ways of coping may not work, the belief systems they have previously used (if any) may no longer be relevant/helpful, and they may face new aspects of spiritual distress directly related to their situation.

Examples of How to Talk About Spirituality

- How are you coping?
- What gives you hope?
- What are you hoping for?
- What brings you joy/comfort/peace?
- What is most important to you?
- Are there any religious or spiritual needs we should be aware of to best care for you?

When a Patient or Colleague Mentions Spirituality

- Body language is critical
- Ask questions after asking permission
- Express appreciation for any sharing
- Advocate as necessary: “You may not have meant that negatively, but that is a harmful thing to say.”
- Maintain curiosity and humility, watching for subtle slide into judgment
- Never attempt to convert or debate beliefs
- Reminder that not all holiday seasons are joyful
- Be mindful that each patient is different and be mindful of assumptions about beliefs

When a Patient or Colleague Mentions Spirituality

How can you respond?

- **Express gratitude** (they are sharing something personal)
- **Demonstrate curiosity** (what do they want me to know about them, how might this impact their care, what does this mean to them)
- **Listen**
- **Reflect**
- **Refer** as needed

This is particularly useful when patients hold beliefs that are unfamiliar and/or very different than your own. Watch for your own biases and triggers.

What About My Own Faith?

- For many people, their faith guides their calling to the work they do and supports them in that work
- Religion and spirituality can give meaning to your work, especially in difficult situations
- Your work may cause spiritual distress or be a source of spiritual strength
- Engaging with others
  - Careful self-reflection: is this about my own need or truly for the other person?
  - If you feel a conflict between needs, seek guidance
  - Look for shared values when promoting spiritual wellness in diverse teams

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Imam Kamau Ayubbi
Shama Mehta, DMin, BCC
Don Lyons, MSW
Chad O’Neil, DMin, MDiv, BCC
Rev. Diane Smith, MDiv, BCC
Rabbi Ben Vineburg, MA, BCC

Moderator: Jennifer Griggs, MD, MPH

Slido Q&A

Welcome Back

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YesRx

A Celebration Video

View at https://yesrx.org/

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POQC Updates

Michael Dudley, POQC

POQC

Patient and Caregiver Oncology Council

https://moqc.org/moqc/poqc/

CORE VALUES

Integrity

Compassion

Collaboration

Empowerment

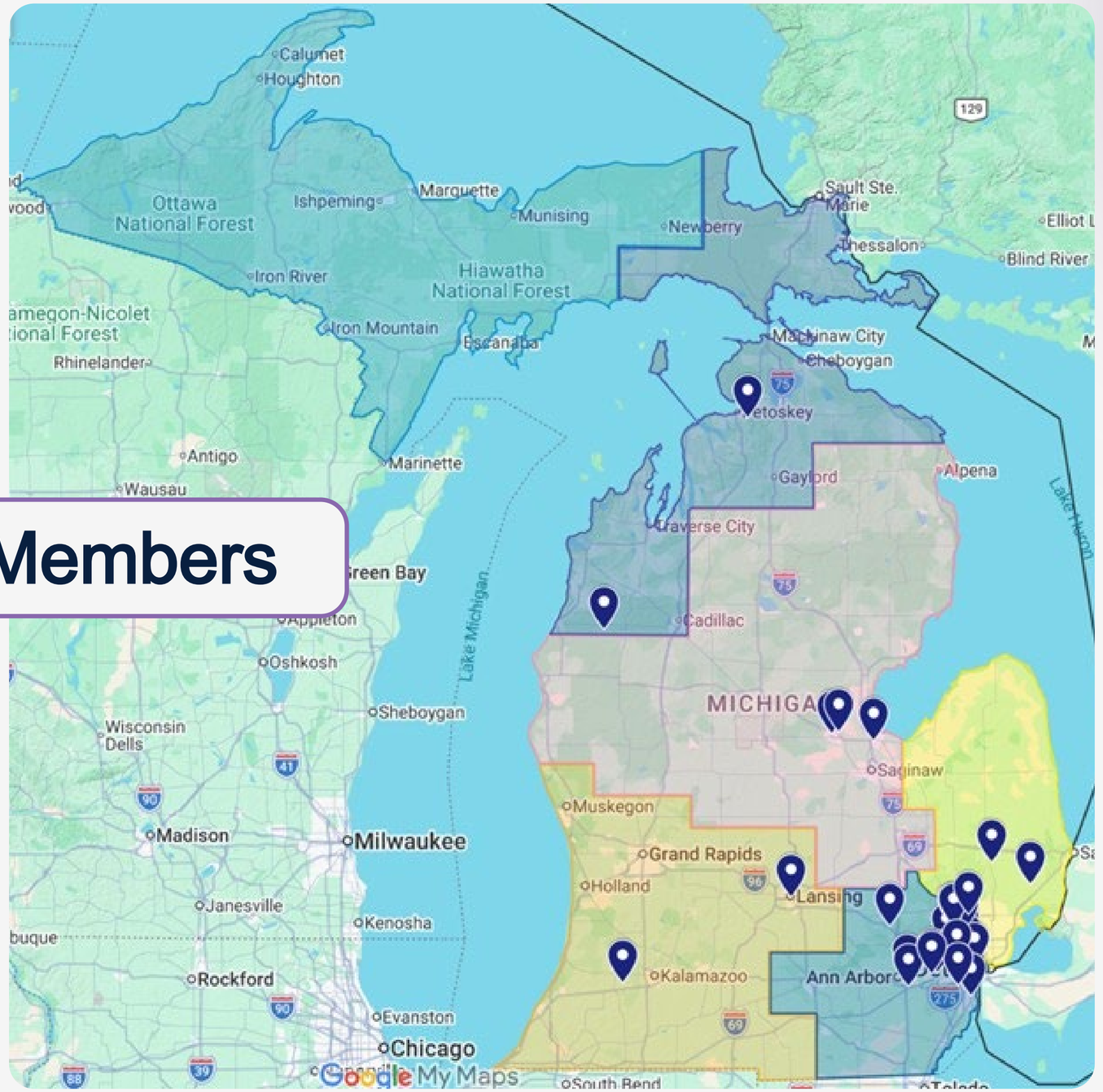
Purpose

We use our lived experiences to improve cancer care in Michigan.

Compassionate, quality cancer care for all

Vision

34 Active Members



Caregiver Navigation Training

5 sessions

61 participants

20 oncology practices

150 Resources

Financial assistance
Transportation
Emotional support
Clinical care

www.CancerHelp.moqc.org

Financial Navigation

Patient Advocate Foundation

Challenges

Disconnect

Support

Financial Navigation

View video at
https://www.youtube.com/watch?v=eZc-zBLNYmg

Cancer care

Non-medical needs

POQC

- Tamera A
- Janet B
- Jerry B
- Tracey C-S
- Lily C
- Tammy C
- Michele C
- Steve C
- Diane D
- Llewellyn D
- Christina D
- Michael D
- Kasey F
- Joan G
- Elise H
- Mark H
- Mike H
- Sharon K
- Pat K
- Stephanie K
- Laura Liz L
- Erika L
- Ayman M
- Marcie P
- Rosanne P
- Sheritha R
- Jacob S
- Mari S
- Terrence S
- Margot S
- Germaine S
- Mark S
- Manal Y

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Clinically Actionable Pharmacogenetics in Oncology: DPYD and Beyond

Amy Pasternak, PharmD, BCPS

Panel

Maja Gibbons, PharmD, BCOP
Thomas Regenbogen, MD
Sam Snowaert , PharmD, BCOP, MBA

Clinically actionable pharmacogenetics in oncology: DPYD and beyond

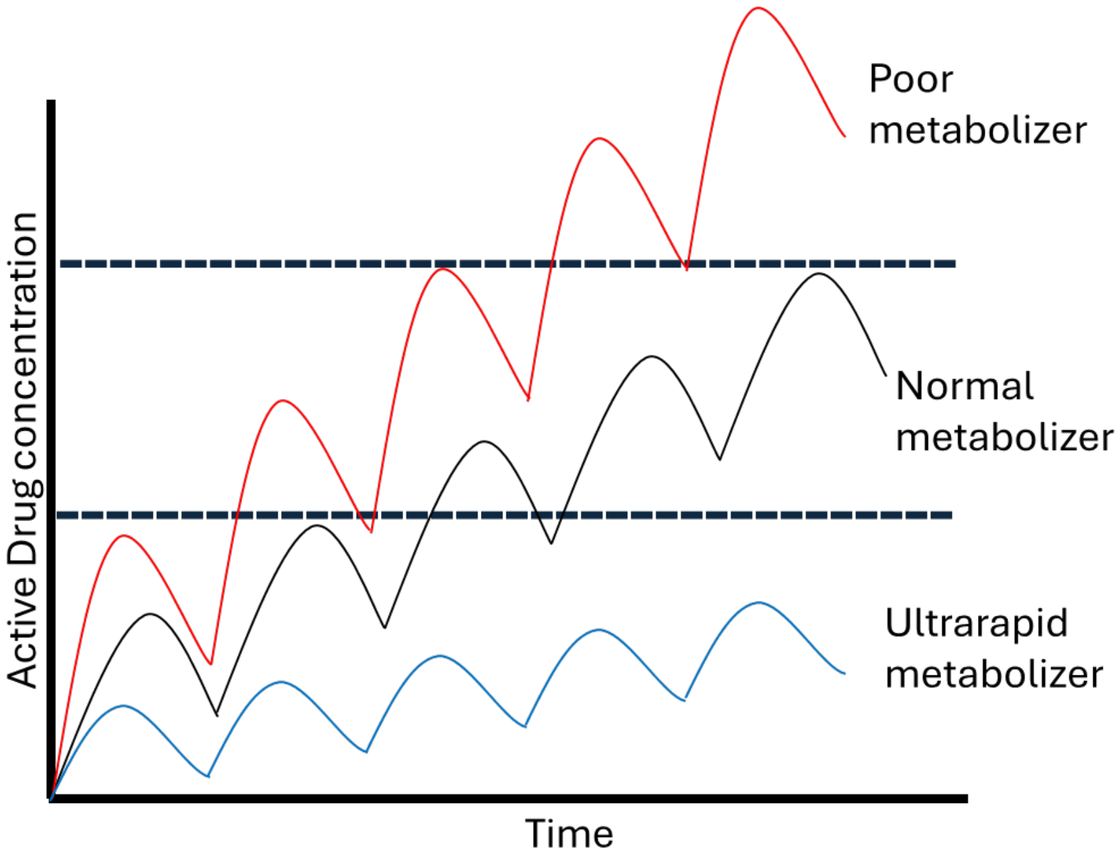
Amy Pasternak, PharmD, BCPS
Clinical Associate Professor
Clinical Pharmacy Specialist- Pharmacogenetics

Objectives

- Review the mechanisms and clinical relevance of common pharmacogenetic interactions in oncology
- Discuss resources and considerations for obtaining and interpreting pharmacogenetic test results to guide prescribing decisions
- Describe considerations for integrating pharmacogenetics into practice

Pharmacogenetic interactions

Inherited genetic changes can alter the function and/or amount of a protein involved in drug pharmacokinetics or pharmacodynamics



Medication toxicity

Pharmacogenetic Recommendations

Clinical Pharmacogenetics Implementation Consortium (CPIC)

- Develop evidence-based guidelines on HOW to apply pharmacogenetic results into patient care
- DO NOT provide recommendations on when to obtain testing
- Summarize evidence for genetic variation, medication use, and impact of genetic variation on medication-related outcomes
- Cpicpgx.org → clinpgx.org

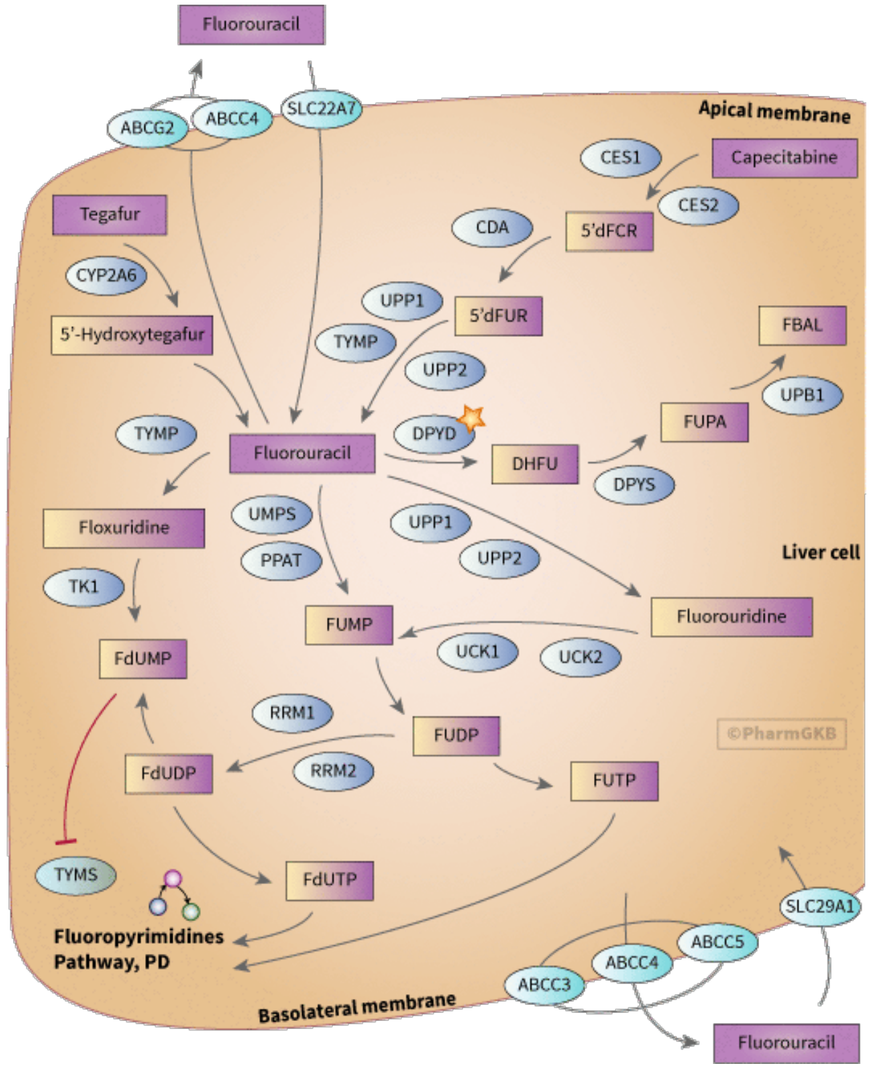
Food and Drug Administration PGx resources

- Table of Pharmacogenomic Biomarkers in Drug Labeling
  - All medications with genetics in package insert
  - May indicate is testing is recommended or required
- Table of Pharmacogenetic Associations
  - FDA identified medications for pharmacogenetic associations with:
    - Data to support therapeutic management
    - Data to suggest impact on safety or efficacy
    - Data to suggest impact on pharmacokinetic properties only

https://www.fda.gov/drugs/science-research-drugs/table-pharmacogenomic-biomarkers-drug-labeling
https://www.fda.gov/medical-devices/precision-medicine/table-pharmacogenetic-associations

Dihydropyrimidine Dehydrogenase (DPYD) and Fluoropyrimidines (FP)

DPYD- Fluoropyrimidines



- DPYD is the rate limiting enzyme for fluoropyrimidine catabolism
- Genetic changes in DPYD can partially or fully reduce enzyme activity
- Accumulation of active metabolites and risk for toxicity

Thorn et al. PharmGKB summary: fluoropyrimidine pathways. Pharmacogenetics and genomics. 2011

DPYD- Fluoropyrimidines

Phenotype	Phenotype Activity Score (AS)	Allele activity
Normal metabolizer (NM)	2	Two normal function alleles
Intermediate metabolizer (IM)	1.5	One normal and one reduced function allele
	1.0	One normal and one no function allele or two reduced function alleles
Poor metabolizer (PM)	0.5	One reduced function and one no-function allele
	0	Two no function alleles

- Patients with a DPYD AS < 2 have a significantly increased risk of CTCAE grade 3+ adverse events or FP-associated mortality when given standard FP doses

Amstutz et al. Clin Pharmacol Ther. 2018.

DPYD- Fluoropyrimidines

- DPYD-guided dosing can reduce risk of severe toxicity, hospitalization, and mortality
  - Odds of severe adverse events are ~90% lower in DPYD IM/PM receiving genotype-guided dosing compared to DPYD IM/PM receiving standard dosing

	DPYD IM* (n=85)	DPYD NM (n=1018)	P-value
FP dose intensity	69% (37-97)	94% (49-128)	-
Grade 3+ toxicity	33 (39%)	231 (23%)	0.0013
Grade 4+ toxicity	4 (5%)	29 (3%)	0.49
FP-associated hospitalization	16 (19%)	140 (14%)	0.26
FP-discontinuation	15 (18%)	175 (17%)	1.0
FP-associated death	1 (1%)	3 (<1%)	0.55

*Patients with a DPYD AS=1.5 received a 25% dose reduction

Table adapted from Henricks et al. Lancet Oncol 2018;19:1459-67; Roncato et al. JAMA Net Open. 2024Dec 2;7(12):e2449441

DPYD- guided dosing recommendations

DPYD Phenotype	Phenotype Activity Score (AS)	CPIC FP dosing recommendation
Normal metabolizer (NM)	2	Initiate at standard dosing
Intermediate metabolizer (IM)	1.5	Reduce initial dose by 50%. Consider escalation based on tolerance
	1.0	
Poor metabolizer (PM)	0.5	Avoid use. If treatment is necessary, reduce initial dose by at least 75%*
	0	Avoid use.

*Recommendation based on limited pharmacokinetic estimates

- CPIC guidelines recommend use of DPYD phenotype testing or FP TDM, especially in PM, however these tests are not commercially available in the U.S.

Amstutz et al. Clin Pharmacol Ther. 2018.

DPYD-Fluoropyrimidines

- FDA labeling for capecitabine and 5-FU now contain Black Box Warnings recommending assessing DPYD genotype prior to prescribing
- NCCN also recommends testing DPYD prior to use

WARNING: SERIOUS ADVERSE REACTIONS OR DEATH IN PATIENTS WITH COMPLETE DPD DEFICIENCY

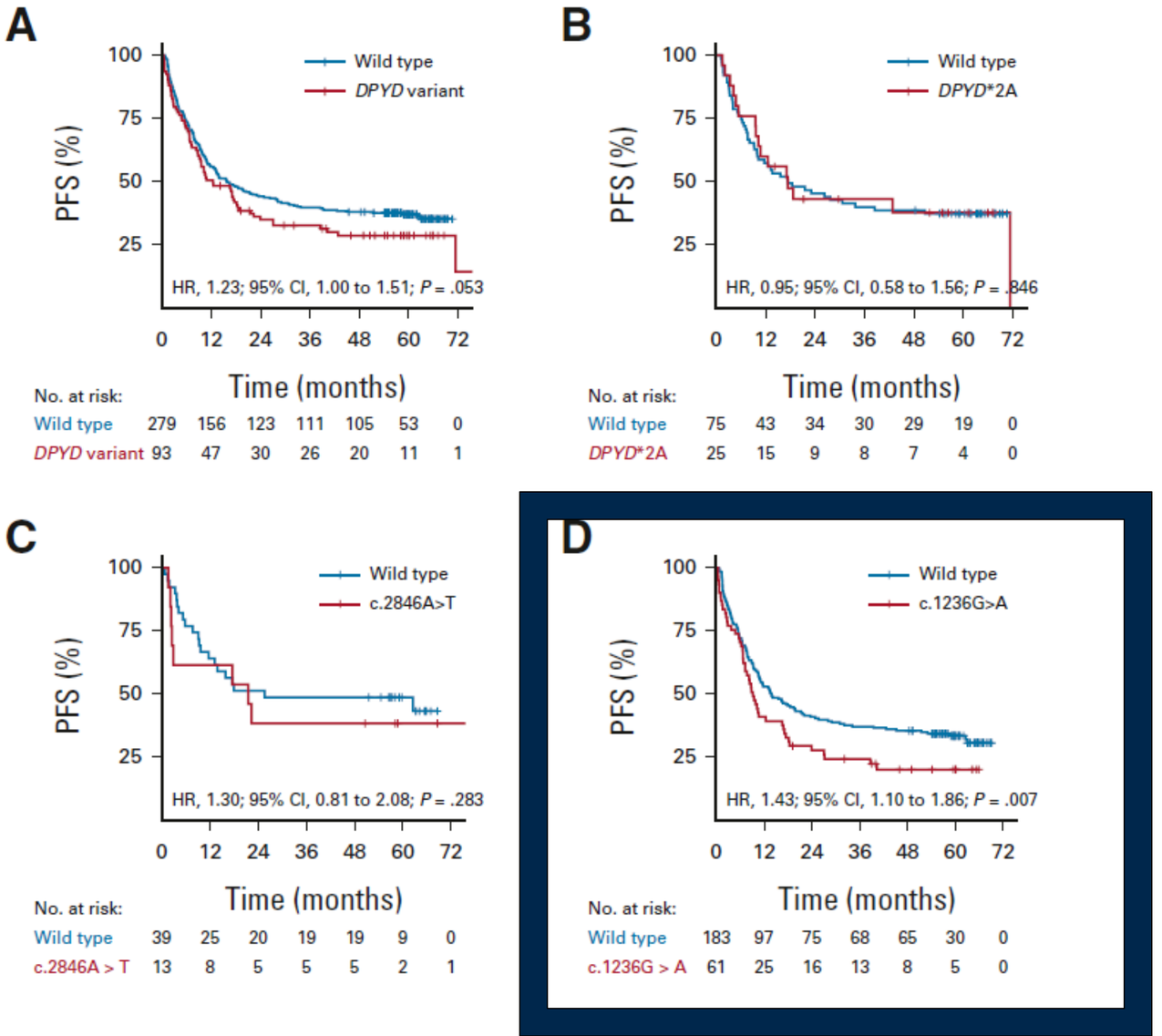
See full prescribing information for complete boxed warning.

Serious adverse reactions or death may occur in patients with complete DPD deficiency. Test patients for genetic variants of *DPYD* prior to initiating fluorouracil unless immediate treatment is necessary. Avoid use of fluorouracil in patients with certain homozygous or compound heterozygous *DPYD* variants that result in complete DPD deficiency. (2.1, 5.1)

Fluorouracil [package insert]; FRESENIUS KABI USA. 2026. Available from:https://www.accessdata.fda.gov/drugsatfda_docs/label/2026/040278Orig1s029lbl.pdf
NCCN Clinical Practice Guidelines in Oncology. Colon Cancer. Version 2.2026.

DPYD-Fluoropyrimidines

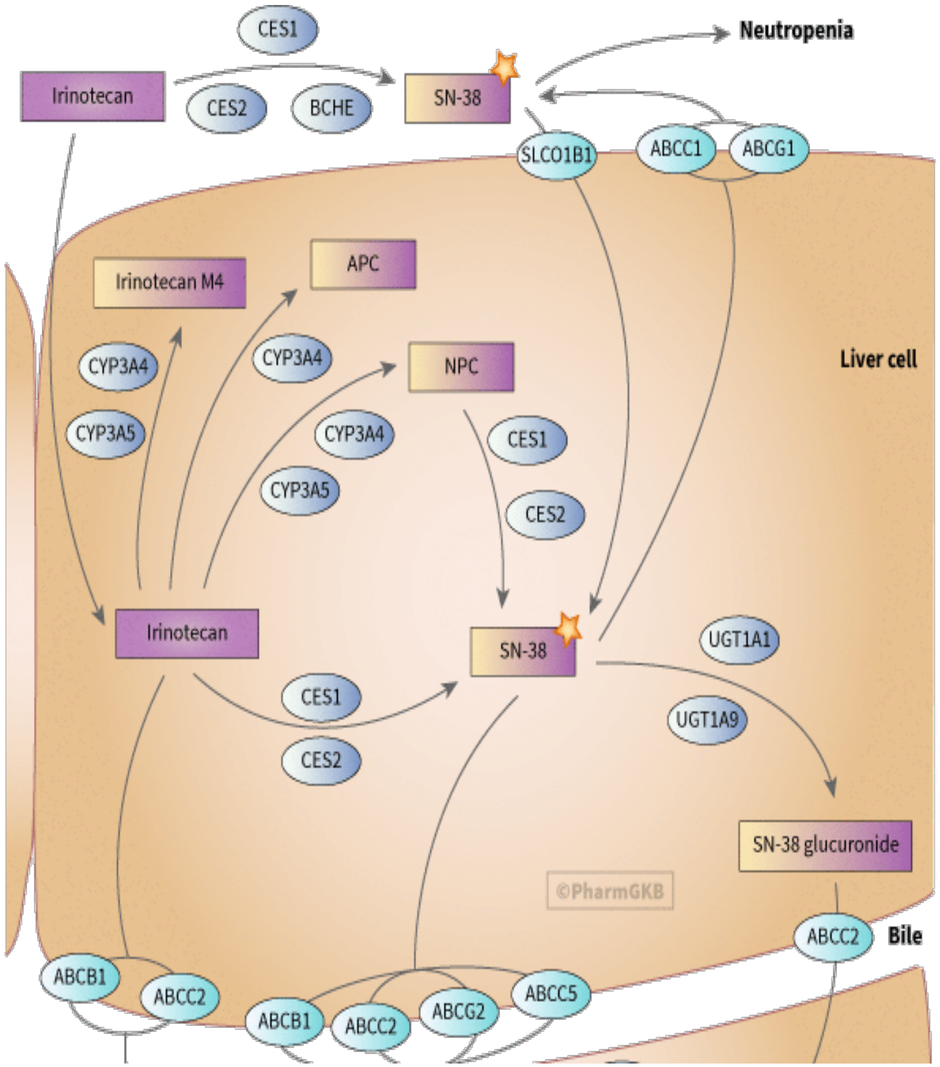
- Guidelines recommend dose escalation based on tolerance
- May have implications on treatment outcomes (PFS)



Knikman et al. J Clin Oncol. 2023.

Uridine Diphosphate Glucuronosyltransferase 1A1 (UGT1A1)

UGT1A1-Irinotecan



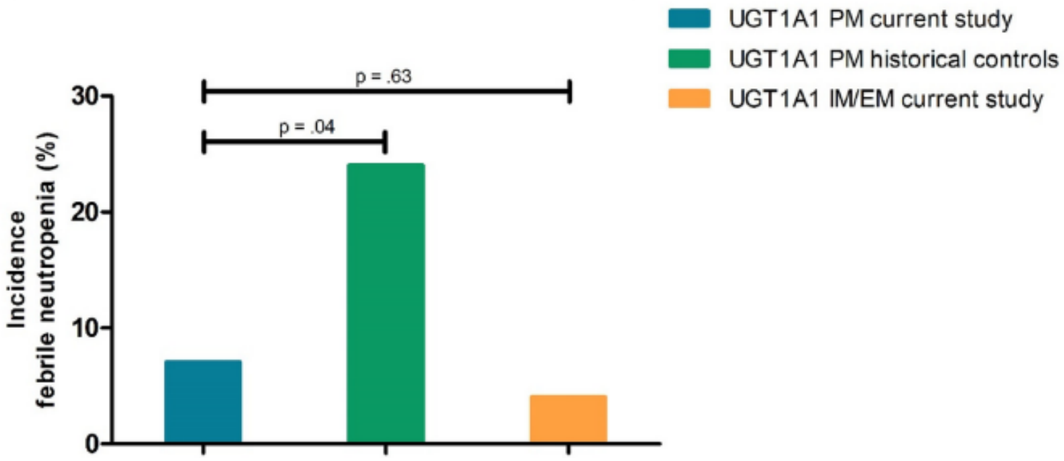
- UGT1A1 is responsible for the inactivation of SN-38
- Genetic changes in UGT1A1 can cause impaired glucuronidation and accumulation of SN-38
- UGT1A1 Poor Metabolizer = Gilbert Syndrome

Whirl-Carrillo et al. Clin Pharmacol Ther. 2021. PharmGKB irinotecan pathway: pharmacokinetics

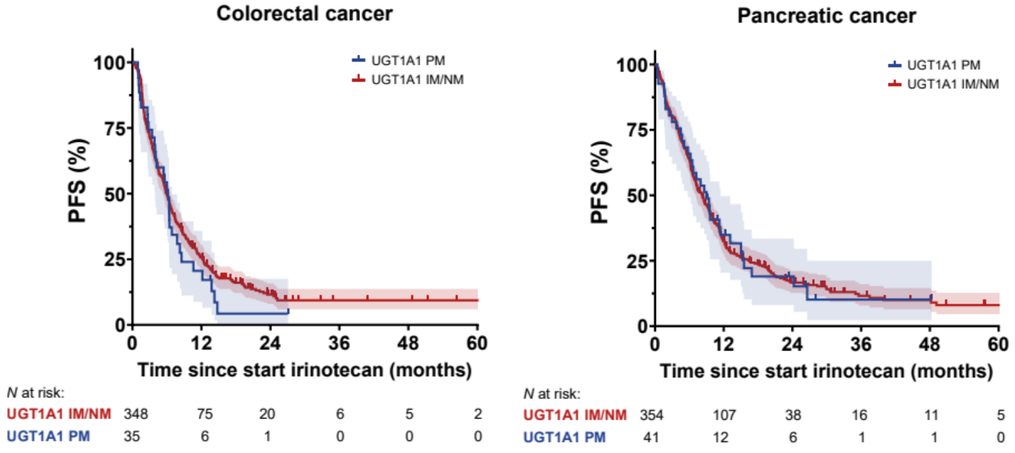
UGT1A1-Irinotecan

- NCCN and FDA recommend initial dose reduction (~30%) when patients are known to be UGT1A1 PM
- This dose reduction significantly reduces the risk of severe toxicity and does not appear to impact clinical outcomes
- Current evidence does not support empiric dose reduction in UGT1A1 IM

Incidence of Febrile Neutropenia in patients receiving UGT1A1-guided irinotecan from Hulsholf et al. (n=350)



Progression free survival in patients receiving UGT1A1-guided irinotecan from Peeters et al. (n=779)



Camptosar (irinotecan) [package insert]. Pfizer Inc. 2024. Approval Label_020571Orig1s056lbl.pdf
NCCN Clinical Practice Guidelines in Oncology. Colon Cancer. Version 2.2026.
Hulsholf et al. Eur J Cancer. 2022 Sep;172:231-233
Peeters et al. Lancet Reg Health Eur. 2026 Feb 23;64:101629

UGT1A1-other medications

Medication	Summary of FDA recommendation for UGT1A1 PM
UGT1A1 substrates	
Belinostat	May have higher exposure and adverse reaction risk. Reduce starting dose to 750 mg/m^2
Sacituzumab govitecan	May have higher exposure and adverse reaction risk. Monitor for adverse reactions and tolerance
UGT1A1 Inhibitors	
Nilotinib	Higher risk for hyperbilirubinemia
Pazopanib	Higher risk for hyperbilirubinemia

FDA Table of Pharmacogenetic Associations. Available from: Table of Pharmacogenetic Associations | FDA

Supportive Care Pharmacogenetics

Supportive Care

Pain	• Opioids • NSAIDs
CINV	• Ondansetron
Anxiety/ Depression	• SSRIs/SNRIs • Tricyclic Antidepressants

- The majority of patients receive at least one additional medication with PGx guidance
- ~15-40% have PGx interactions where personalized prescribing could have been considered

Bernsen et al. Clin Pharmacol Ther. 2025; Patel et al. Support Care Cancer. 2021; Shugg et al. JCO Clin Oncol. 2022

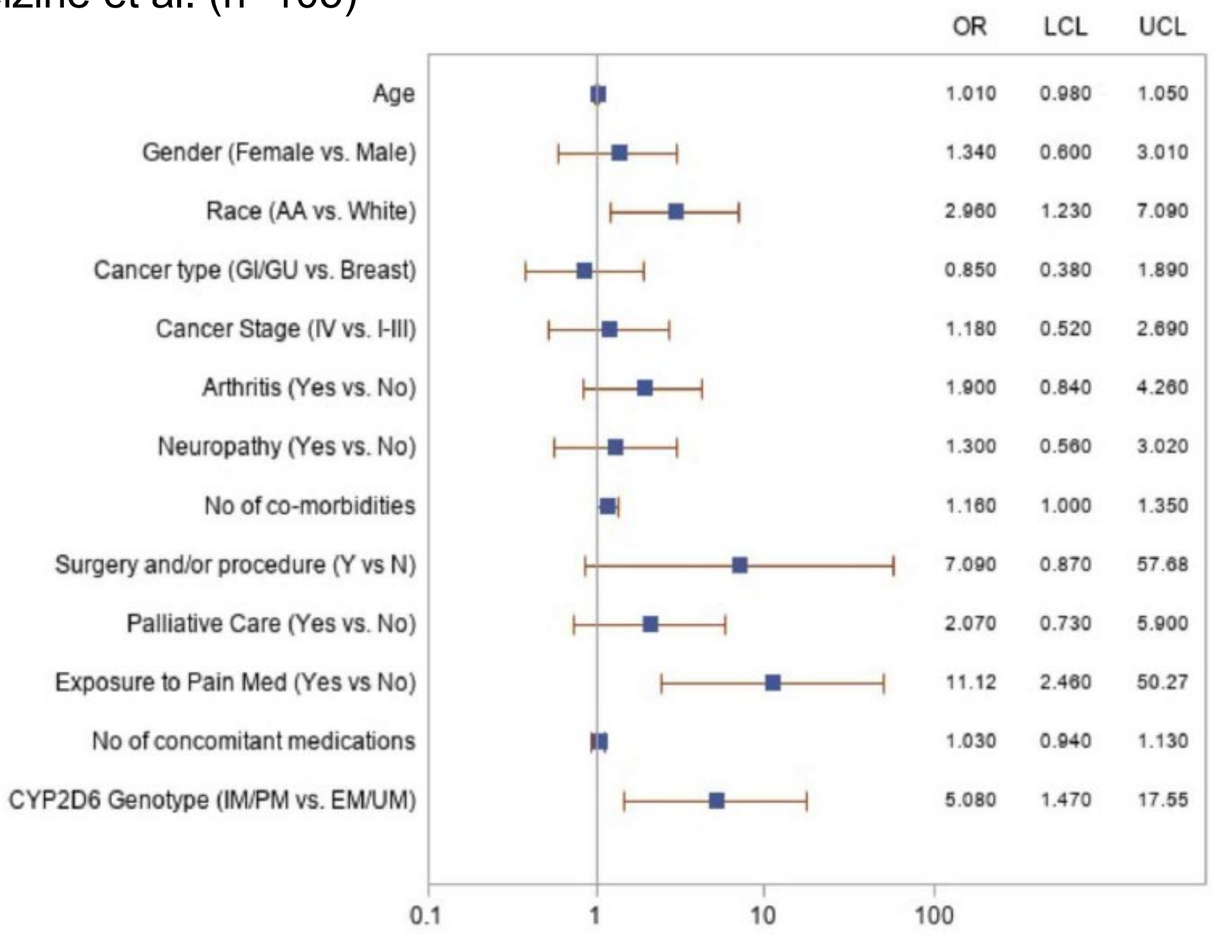
Opioid pharmacogenetics

		CYP2D6 Ultrarapid Metabolizer		CYP2D6 Poor Metabolizer	
Parent compound	**Active metabolite**	**PK effect^**	**Clinical impact**	**PK effect^**	**Clinical impact**
Codeine	Morphine	45% higher morphine AUC	Potential toxic exposure at standard doses	96% lower morphine AUC	Inadequate analgesia Less constipation
Tramadol	O-desmethyl-tramadol	7% higher O-desmethyl-tramadol	Higher rates of adverse events Potential toxic exposure at standard doses	~100% lower O-desmethyl-tramadol AUC	Inadequate analgesia
Hydrocodone	Hydromorphone	--	--	5-fold lower hydromorphone concentrations	?

Kirchheiner J et al. Pharmacogenomics. 2007.; Gasche Y et al. NEJM. 2004; Stamer UM et al. Clin Pharmacol Ther. 2007; Stamer UM et al. Pain 2003; Stamer UM et al. Anesth. Analg. 2008; Crews K et al. Clin Pharmacol Ther. 2021. Otton SV et al. Clin Pharmacol Ther. 1993.

Opioid pharmacogenetics

Forest plot of factors for pain-related hospital encounters from Reizine et al. (n=105)



- Reduced CYP2D6 metabolism significantly increased the odds of a patient experiencing a pain-related hospital encounter
- Patients with reduced CYP2D6 metabolism were more likely to also be exposed to morphine or hydromorphone
- Drug interactions also important to consider

Reizine et al. The Oncologist. 2021; 26:e2042-e2052

Considerations for Integrating Pharmacogenetics into Practice

DPYD-Implementation Framework

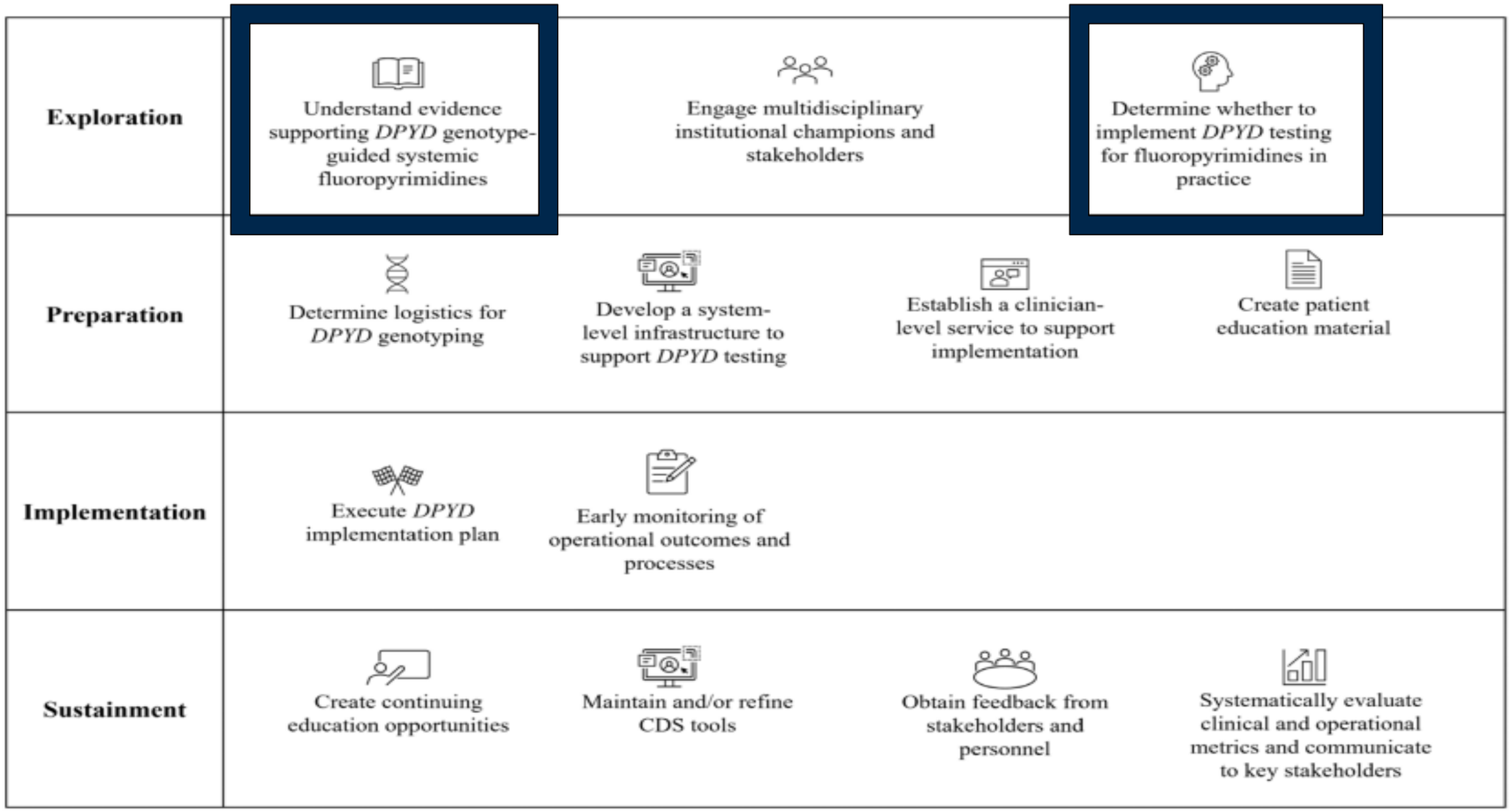


Figure 1 EPIS framework adapted for implementation of *DPYD*-guided fluoropyrimidine dosing.

Ho et al. Clin Pharmacol Ther. 2025

Testing logistics

Molecular testing

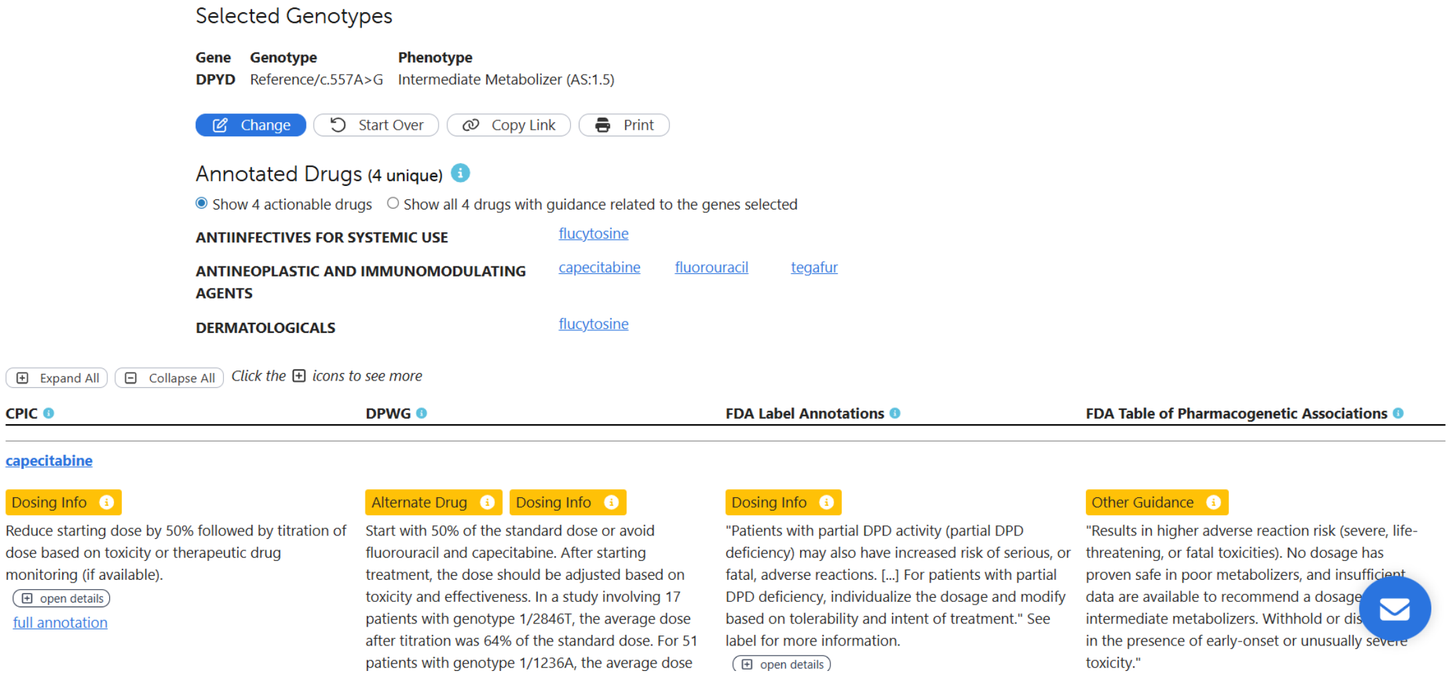
- Some labs are routinely returning DPYD +/- other PGx results
  - May be standard part of report
  - May be “add-on” test
- Actionable results may already be in-hand for your patient “for free”

Pharmacogenetic testing

- Single gene or panel testing options
  - Genetic testing registry
  - Laboratory contracts
- Testing is covered by CMS if CPIC/FDA recommendation available

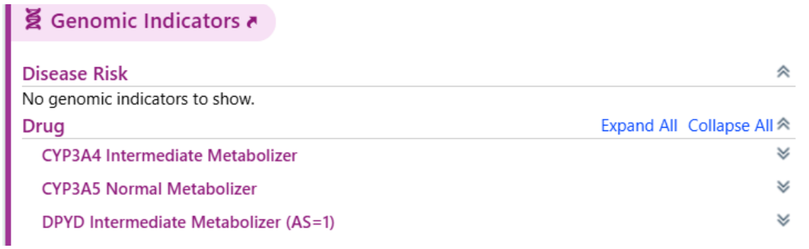
Interpreting testing

- Variability among laboratory reporting
- Recommend use of standardized interpretation tool for results
  - ClinPgx.org

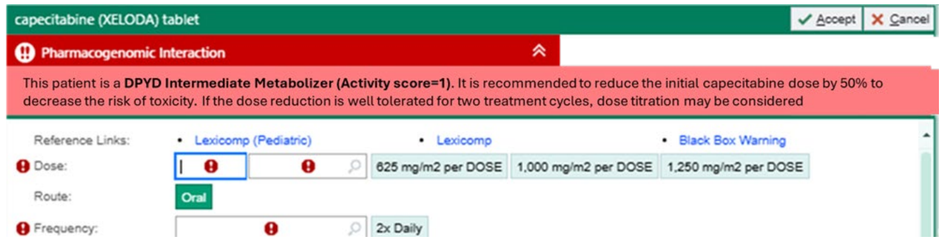


Documenting and Monitoring

- Documentation of results is paramount to medication safety
  - Integrated electronic health record reporting when feasible
    - DPYD- consider activity score
  - Problem list documentation
  - Allergy documentation



- Clinical Decision Support tools



- Educate patients about their result and encourage them to share with their other healthcare providers/family members

Cicali et al. *JACCP*. 2022; Ho et al. Clin Pharmacol Ther. 2025

Conclusions

- Pharmacogenetic testing is becoming increasingly available and has significant implications on the efficacy and/or safety in the treatment and supportive management for patients with cancer
- Pharmacogenetics should be intentionally integrated into clinical workflows
- Best practice resources and guides are available to assist with implementation

Panel Discussion

Question: What resources would you like to see on the MOQC website that would help you with performing DPYD testing and/or applying DPYD-guided dosing for your patients?

Purpose: Understand perceptions of using pre-treatment *DPYD* testing among oncologists in community oncology practices

Instructions

- Please scan the **QR Code** to participate.
- **Anonymous** survey takes ~4 minutes
- **$25 gift card** will be sent to you for participation.
- You can also add your name for a follow-up virtual interview study.
- **IRB approved:**HUM00290872

For any questions, please contact: Karen Farris, PhD (Chair & Mentor) Email: kfarris@umich.edu, or Muhammad Musa, PhD Candidate Email: mmkabir@umich.edu

Thank you for participating in our study!

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Palliative Care and End-of-Life Advisory Committee Update

Erika Lojko, POQC
Natalia Simon, MBA, MA

Measures Conversation

- Palliative care consultation 90 days before death
  - Intent of the measure and feasibility of abstraction
  - Stages III and IV consideration
  - Early palliative care

CAPC MOQC Program Follow-Up

- Billing and documentation workgroup
- Follow-up surveys

Celebrating Cohort 1

Cohort 1 Graduates: Congratulations!

Julie A. Comfort, NP
Cowell Family Cancer Center

Nykea Ellison, NP
KCI at McLaren Flint

Alyssa Brynn Hurtado, PA
Hematology Oncology Consultants

Jennifer Idrissu, NP
Henry Ford Comprehensive Adult Sickle Cell Center

Stephanie Leslie, NP
KCI at McLaren Central

Shannon Mary Wills-Velez, PA, PhD
Henry Ford Macomb Hematology Oncology

Melissa Noa, NP
Munson Healthcare

Shannon Lyn Ochoa, NP
Illumia Health, MOQC by Proxy

Chase Platte, PA
University of Michigan Health West Cancer Center

Jessie Salo, NP
UP Health System - Portage Hematology Oncology

Holly Shank, PA
MyMichigan Sault Hematology Oncology Clinic

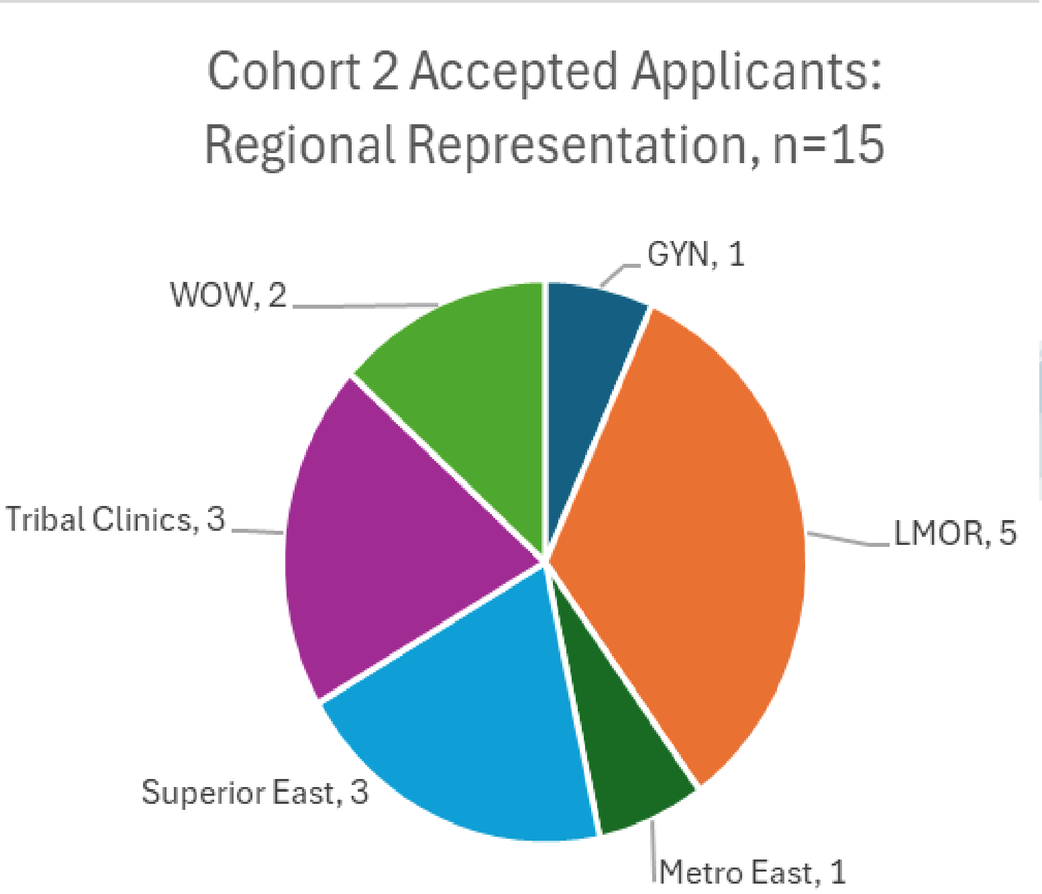
Laura Zyczynski, PA
Michigan Medicine Sarcoma Clinic

Jennifer McArdle, PA
Trinity Health IHA Medical Group

CAPC MOQC Program Update: Cohort 2

Cohort 2: 15 learners

- 10 Nurse Practitioners
- 4 Physician Assistants
- 1 Physician



Cohort 2 Learners

Frank Animikwam, MD
The Little Traverse Bay Bands of Odawa Indians

Andrea Bricker, NP
MOQC by Proxy

Heather Bowers, NP
Karmanos Greater Lansing

Andrea Curtis, NP
Cancer and Hematology Centers

Tina Gastmeier, PA
Great Lakes Cancer Management Specialists

Tami Hiser, NP
Cowell Family Center

Christina Houck-Smith, NP
Cancer and Hematology Centers

Wendy Hunting, NP
Corewell Health

Lauren McFarlane, PA
Michigan Hematology and Oncology Consultants

Jamie Meyer, NP
Corewell Health

Irene Ryan, PA
Michigan Medicine

Alyssa Sanders-Rios, PA
Trinity Health IHA Gynecologic Oncology

Angela Schaub, NP
Grand Traverse Band of Ottawa and Chippewa Indians

Melissa Schaub, NP
Munson Medical Center

Monica Schrage, NP
Mackinac Straits Health

Why are we doing this?

CAPC MOQC Program Reach


Marquette
Petoskey
Alpena
Traverse City
Cadillac
Saginaw
Lansing
Detroit
Kalamazoo
Ann Arbor
LAKE MICHIGAN
LAKE HURON
N
W
E
S

Cohort 3 Update

- Will be open in 2027
- RN, SW, RD, pharmacists, chaplains welcome to apply
- Stay tuned for details!

MOQC
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MEQC Celebration

Lydia Benitez, PharmD, BCOP
Jennifer Griggs, MD, MPH

MOQC Excellence in Quality Certification

2025 Certified Practices

- The Cancer & Hematology Centers
- Covenant Med Oncology
- Henry Ford Health Jackson
- Henry Ford Health Gyn Oncology
- Karmanos Cancer Center Med Oncology
- Karmanos Cancer Center Gyn Oncology
- KCI at McLaren Flint Gyn Oncology
- KCI at McLaren Greater Lansing
- KCI at McLaren Macomb
- KCI at McLaren Northern Michigan
- Munson Healthcare Med Oncology
- Munson Healthcare Gyn Oncology
- Rogel Cancer Center Gyn Oncology
- Trinity Health IHA Med Oncology
- Trinity Health IHA Gyn Oncology
- UMH Sparrow Med Oncology
- UP Health System Portage

2027

If your practice is interested in pursing certification next year, contact us by November 30

moqc@moqc.org

MOQC
MICHIGAN ONCOLOGY QUALITY CONSORTIUM

MOQC Measures

Lydia Benitez, PharmD, BCOP
Jennifer Griggs, MD, MPH

2026 VBR & MEQC Measures

Measure Description	2025 Target	2026 Target
Complete **family history** documented for patients with invasive cancer	35%	**40%**
Olanzapine prescribed as part of a 4-drug antiemetic regimen with cycle 1 high emetic risk	60%	**65%**
Hospice enrollment	65%	**65%**
Median days on **hospice**	N/A	**11 days**
Palliative care consultation more than 90 days before death	20%	**25%**

Standard VBR: 5%; scored at REGIONAL level
MEQC VBR: 15%; scored at PRACTICE level

Tobacco Cessation Measure

Measure Description	2025 Target	2026 Target
Tobacco cessation counseling or referral for tobacco users (includes use of vaping and chewing tobacco)	75%	**68%**

Standard VBR: 2%; scored at COLLABORATIVE level

2026 Measure Targets

MEQC Measure

Total eligibility: **15%**

VBR Measure

Total eligibility: up to **7%**

MEQC practices are only eligible for the 15% VBR

2026 Additional Criteria for Receiving VBR

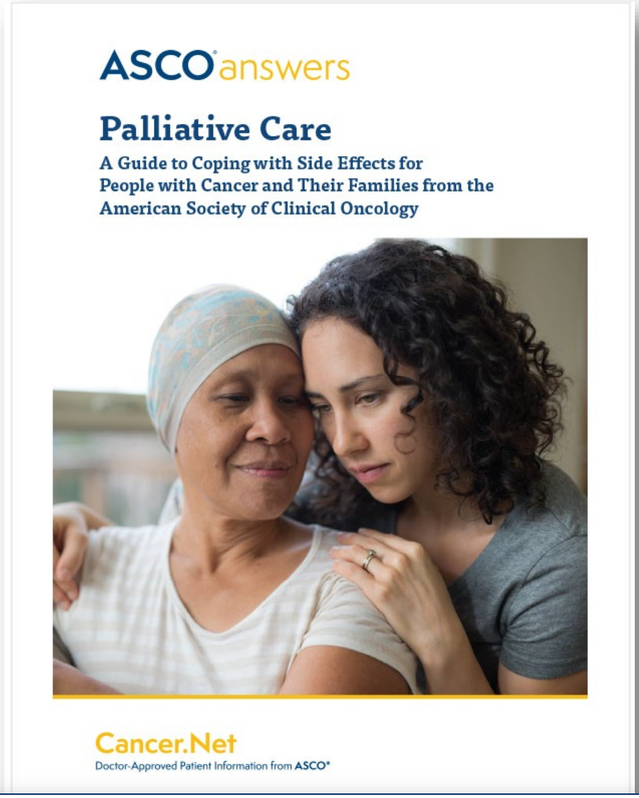
Practice Level	At least **one physician and one practice manager or other change agent** from the practice must attend **a fall in-person** MOQC regional meeting and **at least one** biannual meeting during that year.
	Practice must have **10 charts** in the denominator per VBR measure per round. • Exceptions may be made for EOL measures.
Physician Level	Provider must be enrolled in **PGIP** for at least one year.

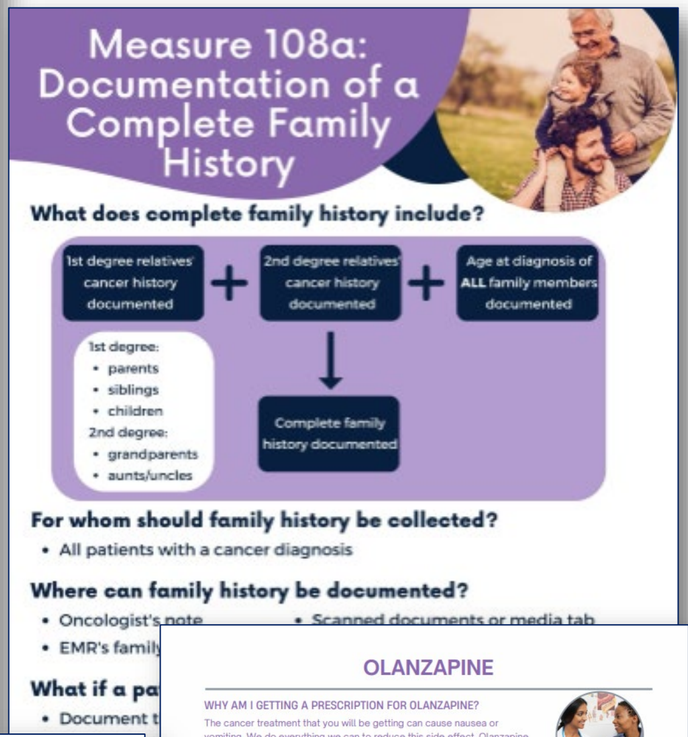
MOQC Resources

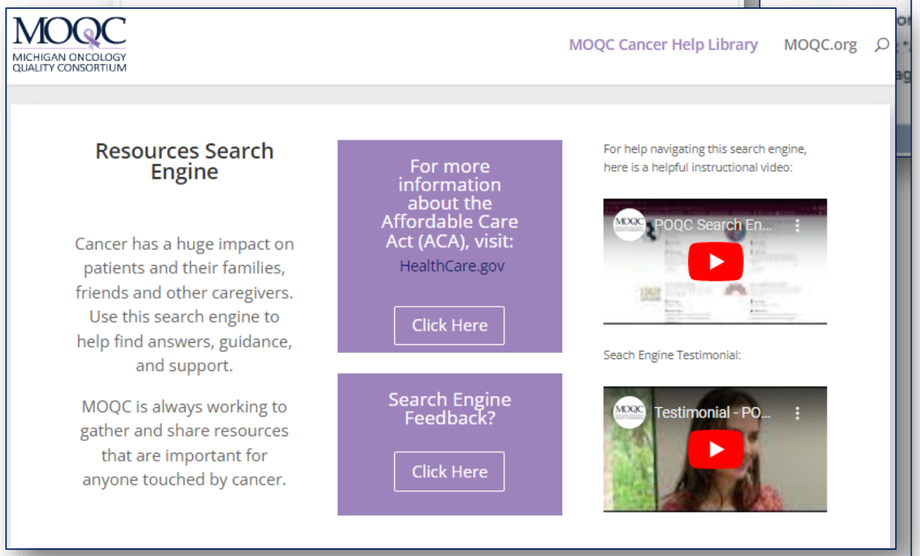
- MOQC has a variety of free resources for your **patients**, **caregivers**, and **clinicians**

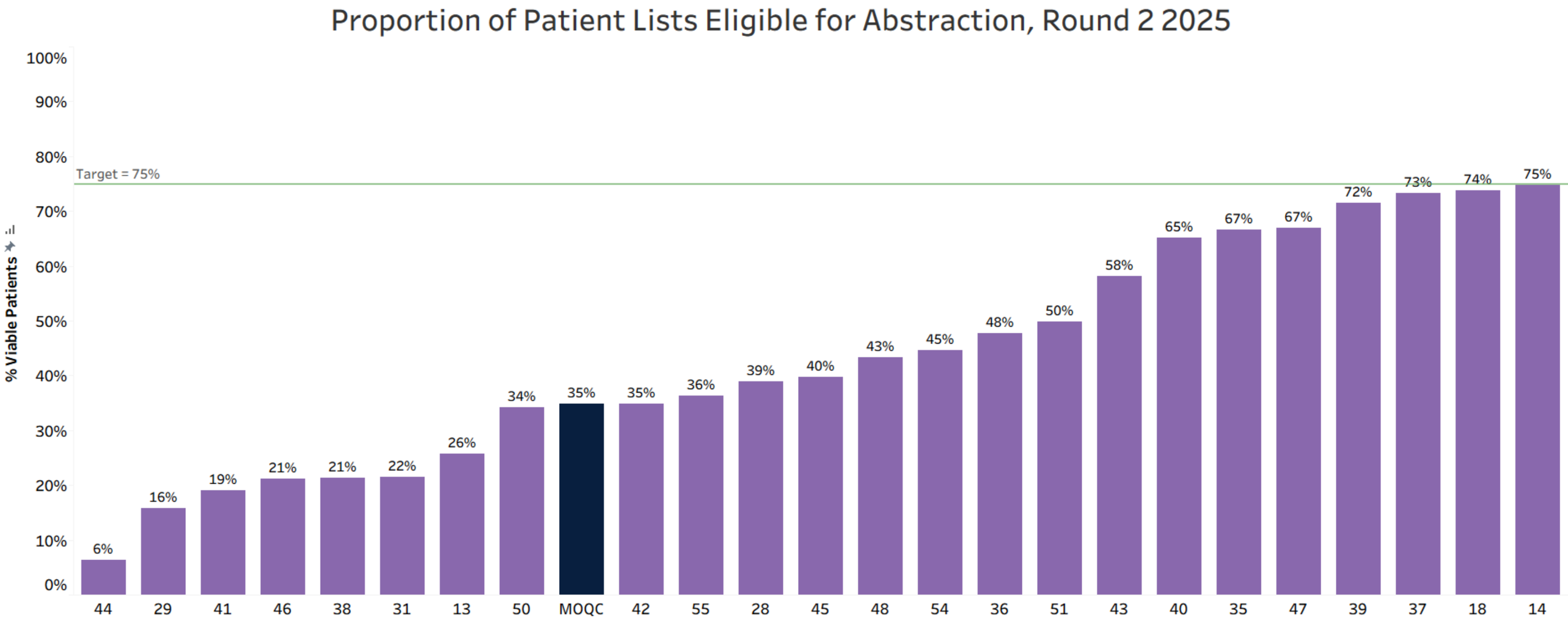
- **Electronic** and **printed** formats available

www.moqc.org

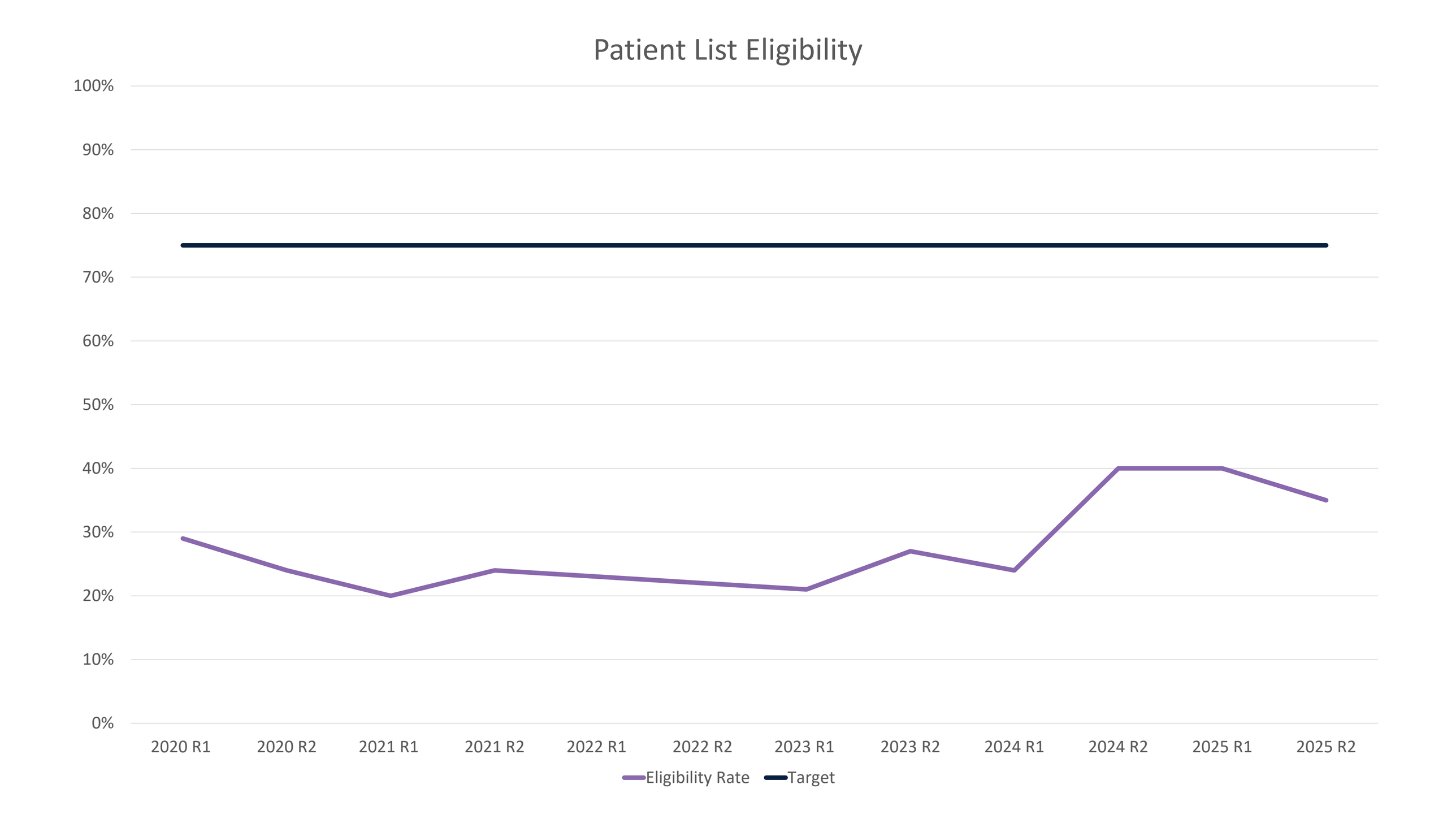








MOQC Abstractors opened **9,567** charts and only **4,422** qualified for abstraction.


Patient List Eligibility
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2020 R1
2020 R2
2021 R1
2021 R2
2022 R1
2022 R2
2023 R1
2023 R2
2024 R1
2024 R2
2025 R1
2025 R2
Eligibility Rate
Target

Reminder: Identified Data

Practice data will include the identified practice name.

Reminder: all data shown are confidential.

Measures

- Tobacco cessation counseling or referral
- Complete family history
- Designated patient advocate documentation
- Palliative care consultation more than 90 days before death*
- Olanzapine as part of 4-drug regimen with Cycle 1 high emetic risk chemotherapy
- Screening for non-medical needs

*Uses end-of-life chart selection criteria

Practices with fewer than 5 eligible cases per measure are not displayed.

Chart Selection Criteria for Presented Data

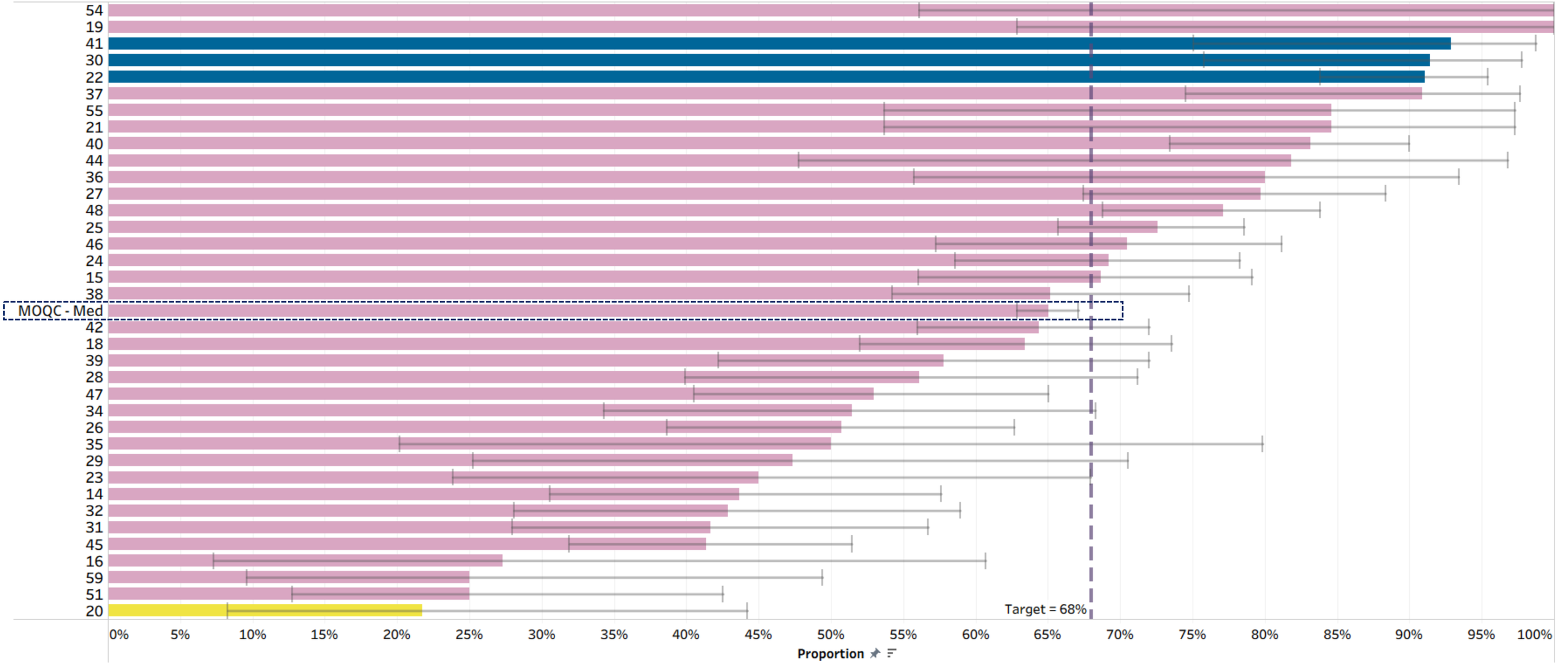
Abstracted January 1, 2025 – June 30, 2026

Eligible Patient Criteria
18 or older at diagnosis
Invasive malignancy or hematologic malignancy

Diagnosis & Visit Window
Diagnosed: 12/1/2023 – 3/31/2026
First Office Visit: 12/1/2023 – 5/31/2026
2 Office Visits (practitioner): 10/1/2024 – 5/31/2026

VBR

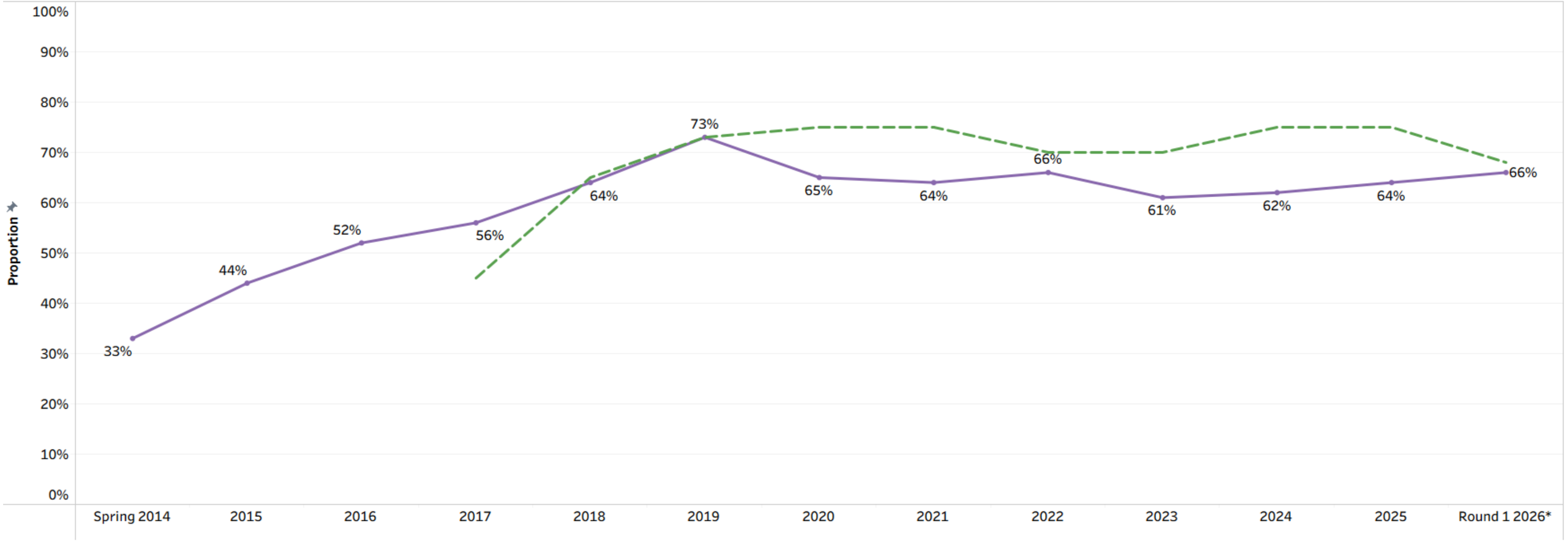
101b: Tobacco Cessation Counseling or Referral for Tobacco Users Once a Year
5/16/25 - 5/15/26, n = 1,949



Performance Compared to Prior Year
- No Significant Change
- Improved
- Worsened

VBR

101b: Tobacco Cessation Counseling or Referral for Tobacco Users Once a Year



*Round 1 2026 data is through 5/15/2026. The abstraction round ends on 6/30/2026, so this number may change by the end of the round.

Color Legend

- MOQC Performance
- Target

Poll

A large study of over 4,000 cancer patients compared patients who quit smoking within 6 months of their diagnosis (early quitters) to others who continued to smoke and found:

A. There was no difference in survival time

B. Early quitters gained 9 months of life

C. Early quitters gained 1.8 years of life

D. Early quitters gained about 5 years of life.

Answer

C. Early quitters gained 1.8 years of life

Billing Codes

CPT 99406
Intermediate smoking & tobacco-use cessation counseling visit (>3 and ≤10 min)

CPT 99407
Intensive smoking & tobacco-use cessation counseling visit (>10 min)

Cinciripini et al. JAMA Oncol 2024

Tobacco Measure Update

Update coming to Tobacco Cessation measure in 2027:

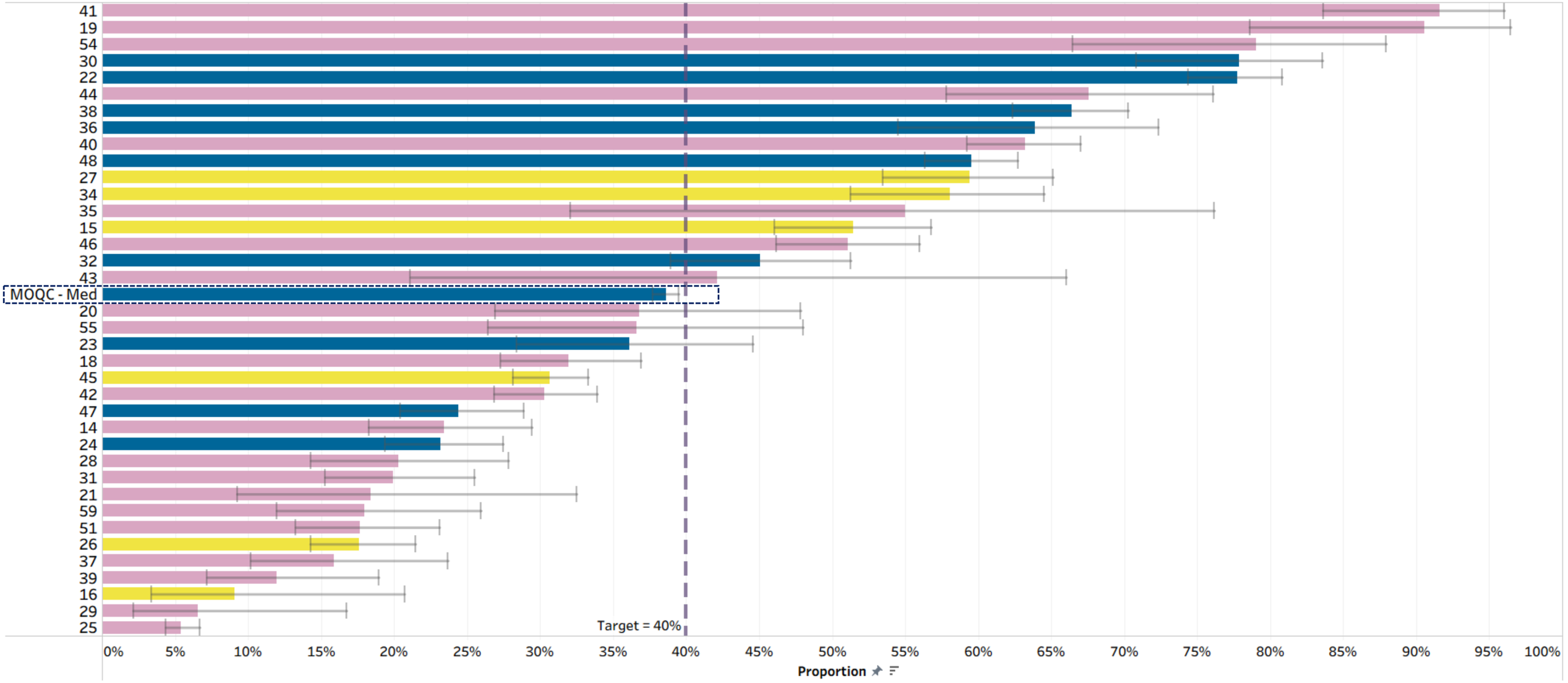
- Automated referral will no longer fulfill the measure
- Brief counseling and/or pharmacotherapy prescription required
    - Counseling does not need to be provided by the physician

MEQC

VBR

108a: Complete Family History Documented for Patients with Invasive Cancer

5/16/25 - 5/15/26, n = 11,881



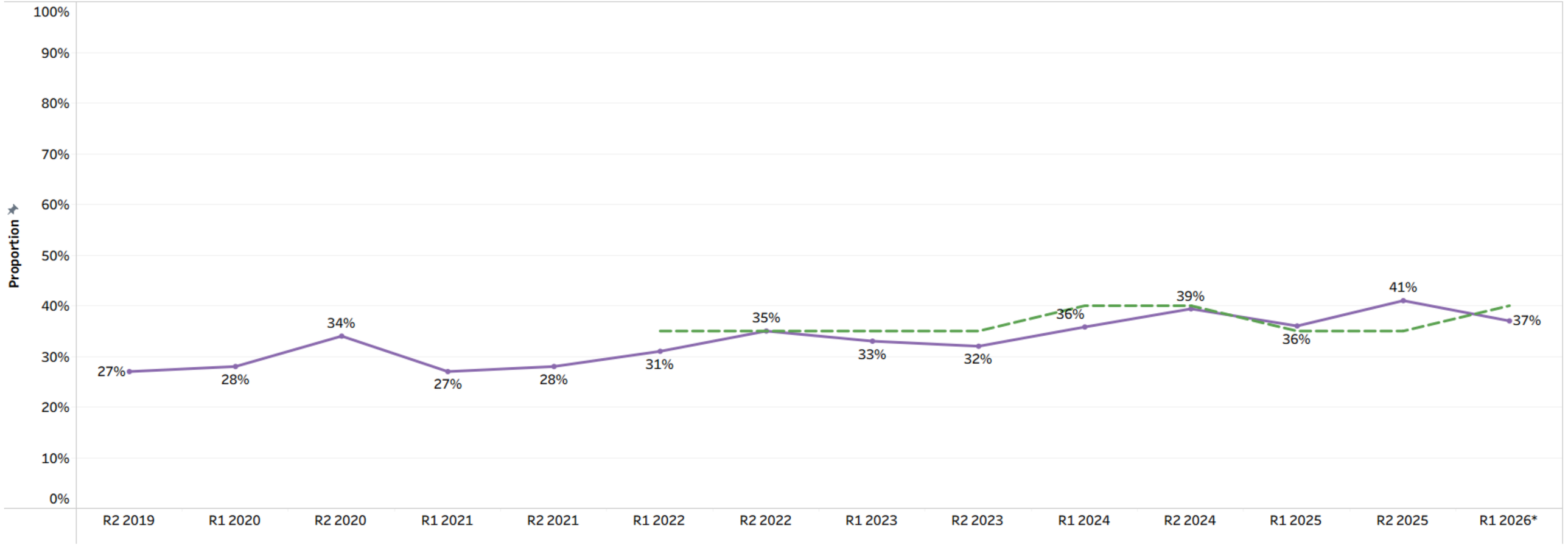
Performance Compared to Prior Year

- No Significant Change
- Improved
- Worsened

MEQC

VBR

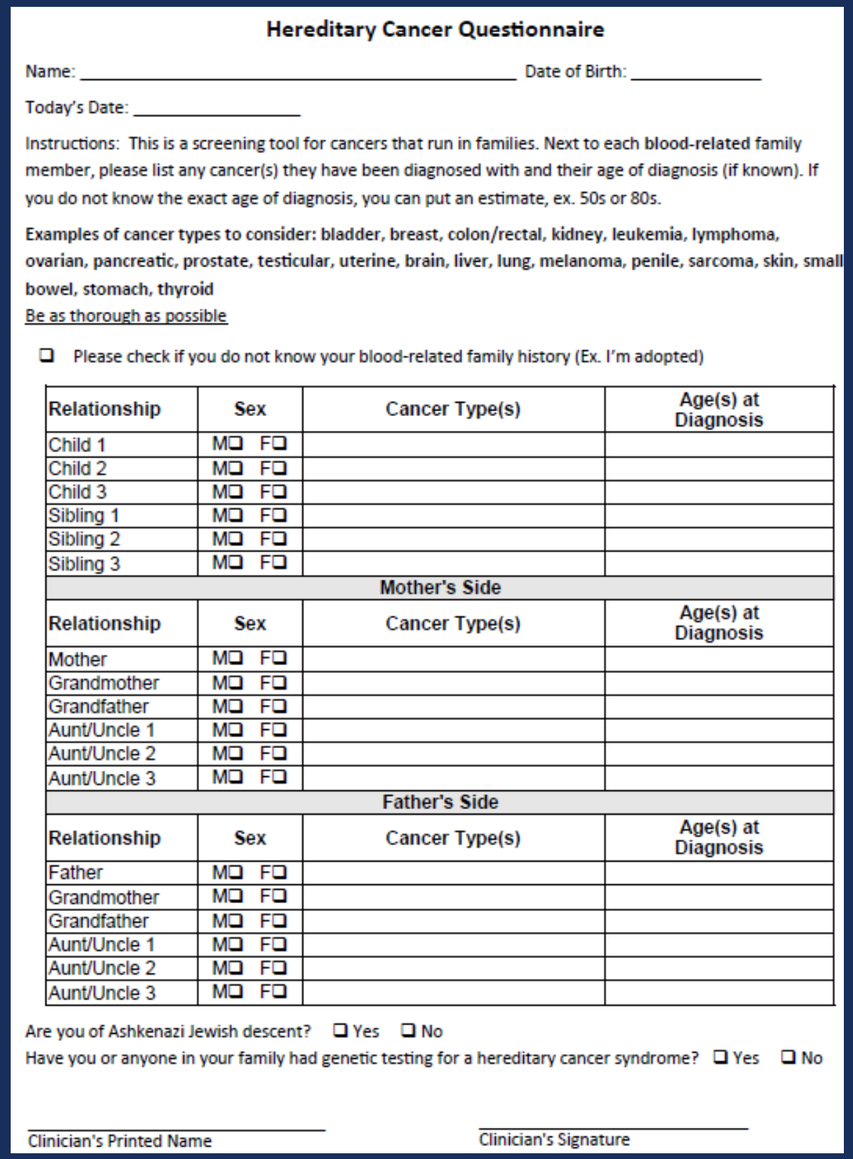
108a: Complete Family History Documented for Patients with Invasive Cancer



*Round 1 2026 data is through 5/15/2026. The abstraction round ends on 6/30/2026, so this number may change by the end of the round.

Color Legend

- MOQC Performance
- Target



Hereditary Cancer Questionnaire

Name: _____ Date of Birth: _____

Today's Date: _____

Instructions: This is a screening tool for cancers that run in families. Next to each blood-related family member, please list any cancer(s) they have been diagnosed with and their age of diagnosis (if known). If you do not know the exact age of diagnosis, you can put an estimate, ex. 50s or 80s.

Examples of cancer types to consider: bladder, breast, colon/rectal, kidney, leukemia, lymphoma, ovarian, pancreatic, prostate, testicular, uterine, brain, liver, lung, melanoma, penile, sarcoma, skin, small bowel, stomach, thyroid

Be as thorough as possible

❑ Please check if you do not know your blood-related family history (Ex. I'm adopted)

Relationship	Sex	Cancer Type(s)	Age(s) at Diagnosis
Child 1	M❑ F❑		
Child 2	M❑ F❑		
Child 3	M❑ F❑		
Sibling 1	M❑ F❑		
Sibling 2	M❑ F❑		
Sibling 3	M❑ F❑		
Mother's Side			
Relationship	**Sex**	**Cancer Type(s)**	**Age(s) at Diagnosis**
Mother	M❑ F❑		
Grandmother	M❑ F❑		
Grandfather	M❑ F❑		
Aunt/Uncle 1	M❑ F❑		
Aunt/Uncle 2	M❑ F❑		
Aunt/Uncle 3	M❑ F❑		
Father's Side			
Relationship	**Sex**	**Cancer Type(s)**	**Age(s) at Diagnosis**
Father	M❑ F❑		
Grandmother	M❑ F❑		
Grandfather	M❑ F❑		
Aunt/Uncle 1	M❑ F❑		
Aunt/Uncle 2	M❑ F❑		
Aunt/Uncle 3	M❑ F❑		

Are you of Ashkenazi Jewish descent? ❑ Yes ❑ No

Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? ❑ Yes ❑ No

_____ _____

Clinician's Printed Name Clinician's Signature

Examples of Dot Phrases for Family History

- *Include notable family history.* No other family history of cancer in any first- or second-degree relative.

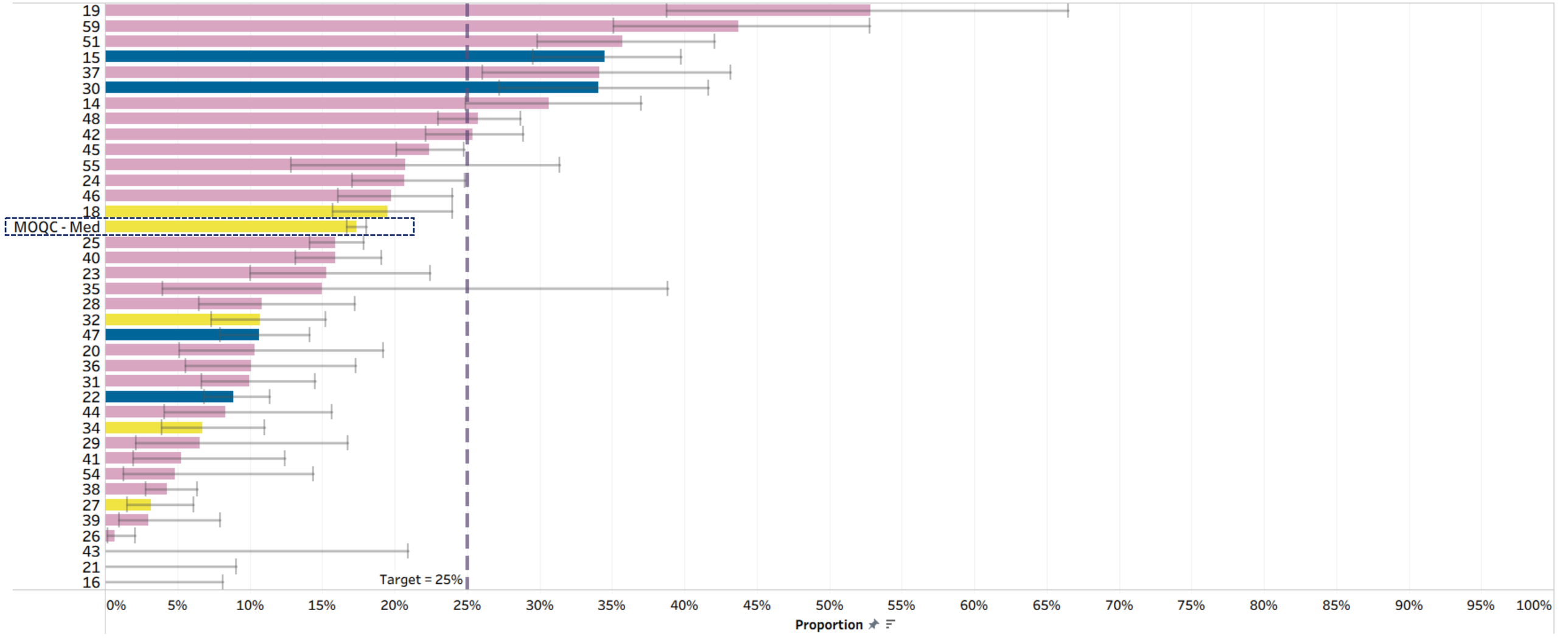
- No other known cancer or blood disorder in first- or second-degree relatives.

- A comprehensive family history of 1st and 2nd degree relatives was reviewed, including any cancer diagnoses and age of onset. No known family history of cancer was reported unless otherwise documented above.

- Family history was reviewed for all 1st and 2nd degree relatives, including cancer diagnoses, type of cancer, and age of onset. The patient reports no known family history of cancer unless otherwise specified above.

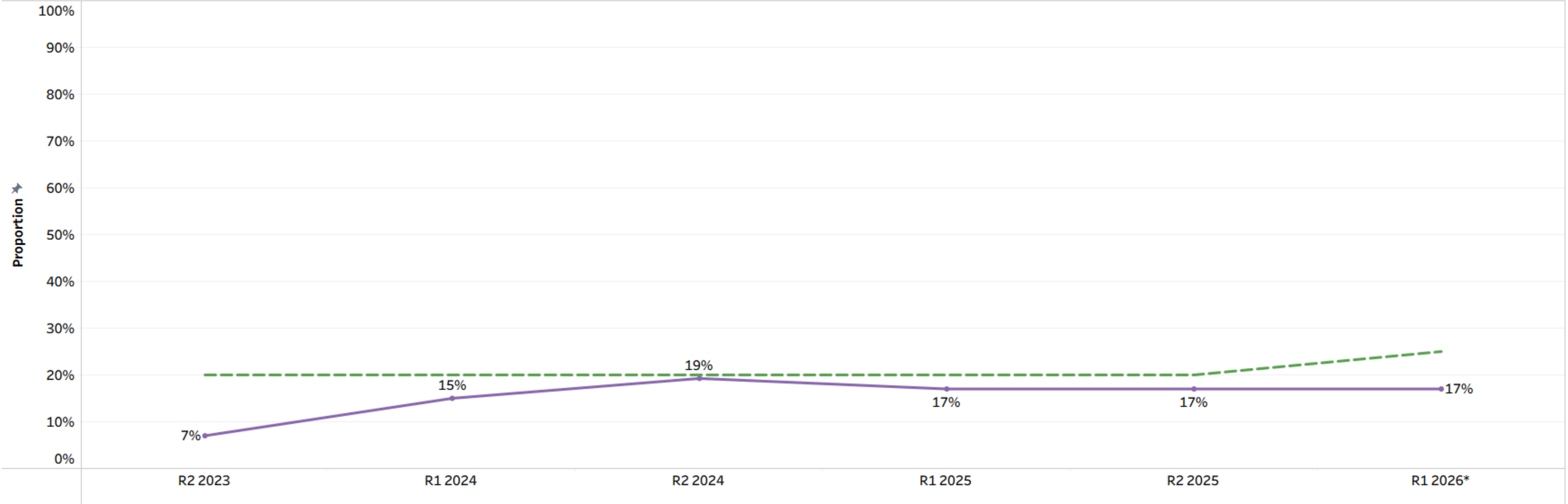
- All known family history documented in Epic Family History Tool, including age and cancer type if known. Per patient, no other 1st or 2nd degree relatives with history of cancer.

103: Designated Advocate Documented on a Legally Recognized Document in the Inpatient or Outpatient Medical Record
5/16/25 - 5/15/26, n = 11,881



Performance Compared to Prior Year
- No Significant Change
- Improved
- Worsened

103: Designated Advocate Documented on a Legally Recognized Document in the Inpatient or Outpatient Medical Record



*Round 1 2026 data is through 5/15/2026. The abstraction round ends on 6/30/2026, so this number may change by the end of the round.

Color Legend

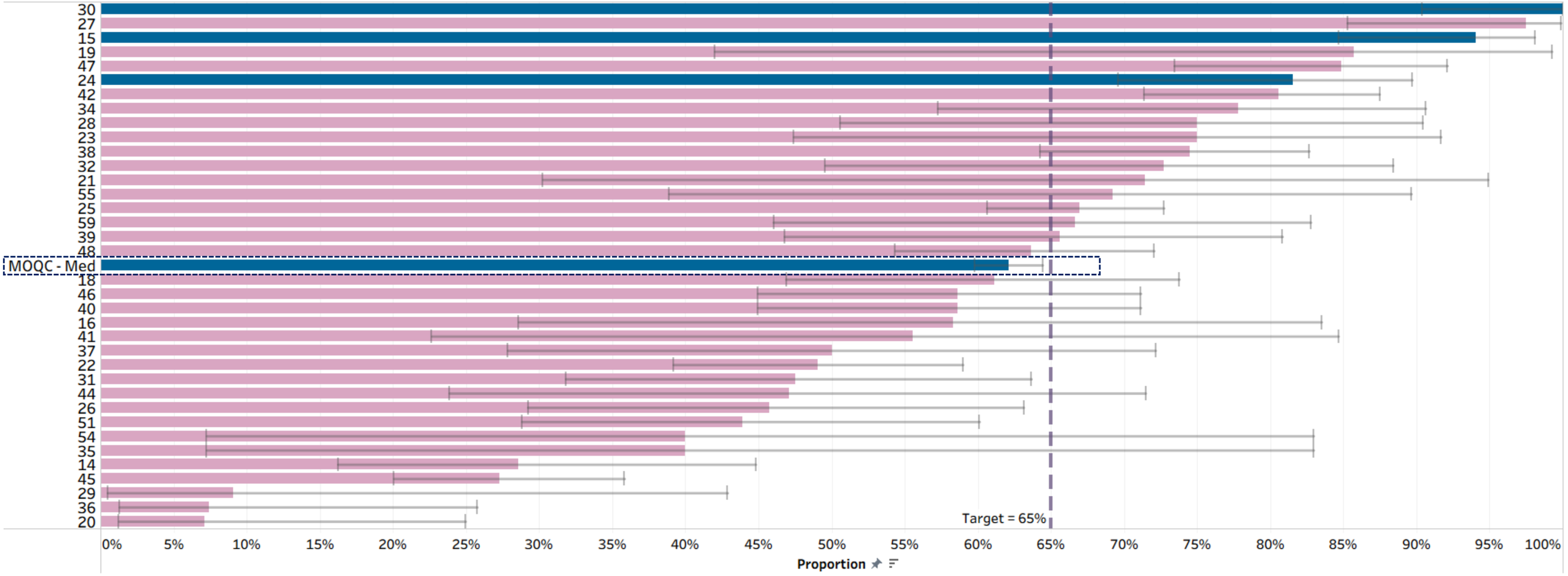
- MOQC Performance
- Target

MEQC

VBR

115: Olanzapine Prescribed as Part of a 4-Drug Antiemetic Regimen with Cycle 1 High Emetic Risk Chemotherapy

5/16/25 - 5/15/26, n = 1,719



Patients receiving treatment on antiemetic clinical trial excluded.

Performance Compared to Prior Year

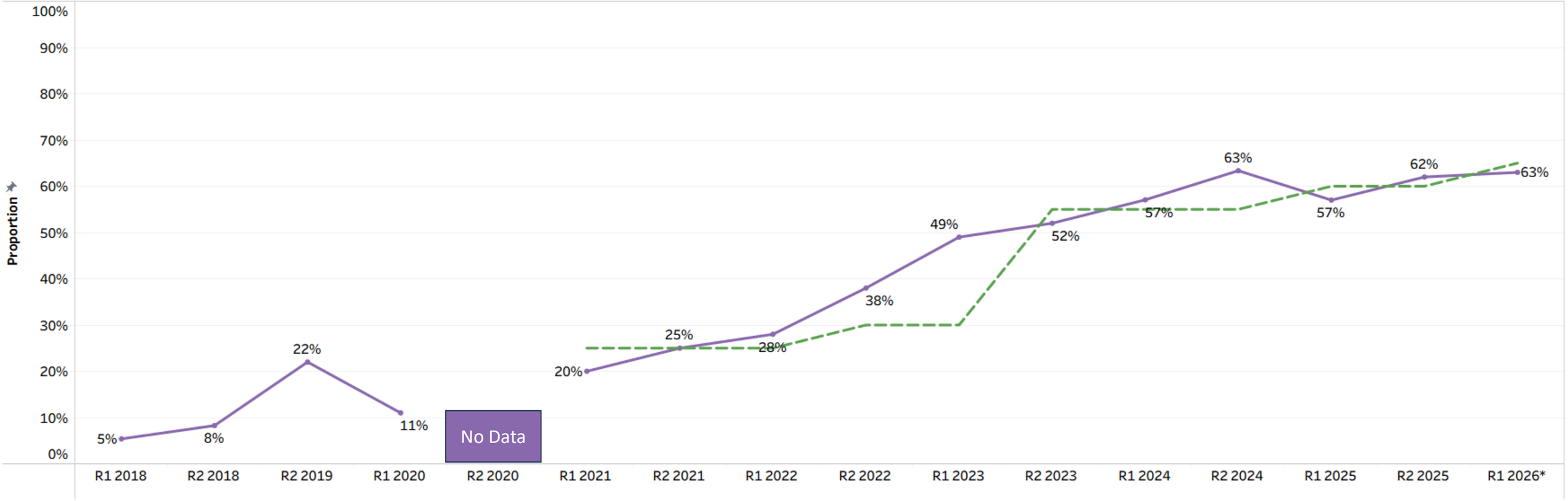
No Significant Change

Improved

MEQC

VBR

115: Olanzapine Prescribed as Part of a 4-Drug Antiemetic Regimen with Cycle 1 High Emetic Risk Chemotherapy



*Round 1 2026 data is through 5/15/2026. The abstraction round ends on 6/30/2026, so this number may change by the end of the round.

Color Legend

- MOQC Performance
- Target

Poll

A 52-year-old woman is starting chemotherapy and tells her care team:

"Honestly, I'm more worried about nausea and vomiting than anything else.“

Even with today's supportive medications, how often do patients receiving highly emetogenic chemotherapy end up needing an emergency department visit or hospitalization because of nausea and vomiting?

A. Less than 1%

B. About 10%

C. About 25%

D. More than 50%

Answer

C. About 25%

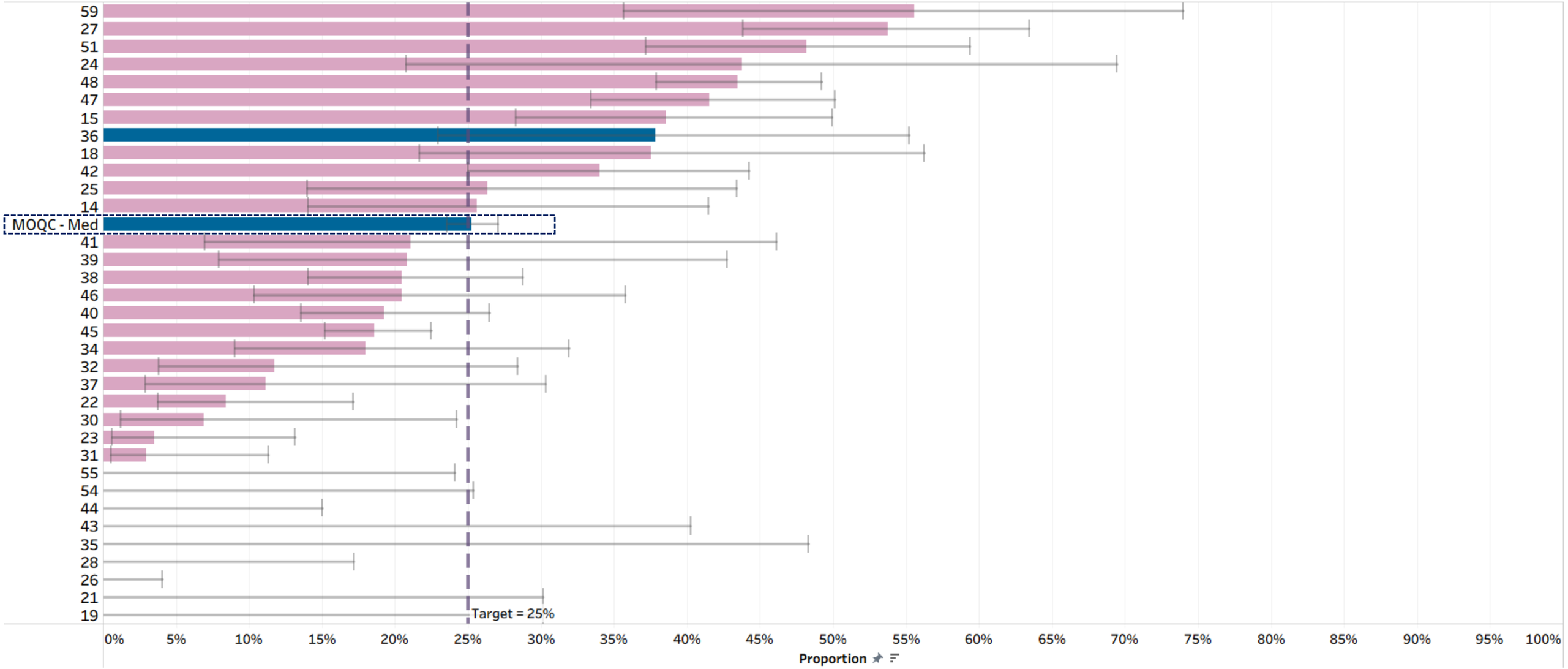
Prince et al., Eur J Cancer Care 2019/Tervonen et al, Europ J Cancer Care 2019

MEQC

VBR

129: Palliative Care Consultation More than 90 Days Before Death

5/16/25 - 5/15/26, n = 2,436



Performance Compared to Prior Year

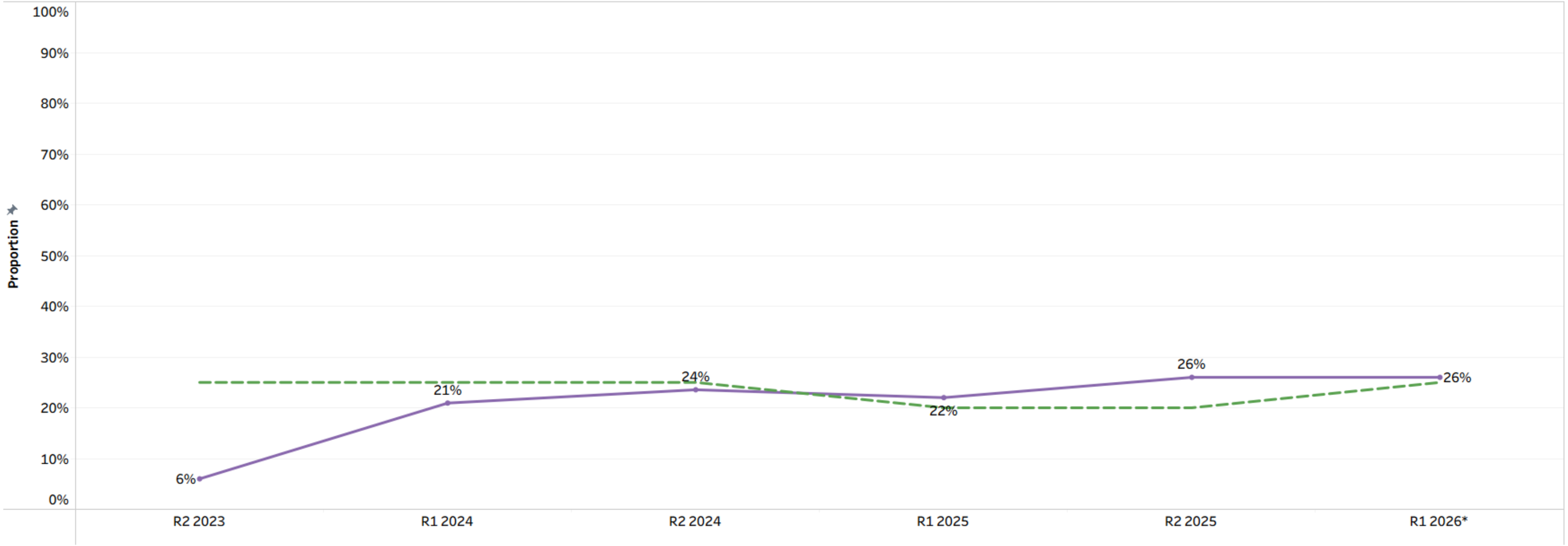
No Significant Change

Improved

MEQC

VBR

129: Palliative Care Consultation More than 90 Days Before Death



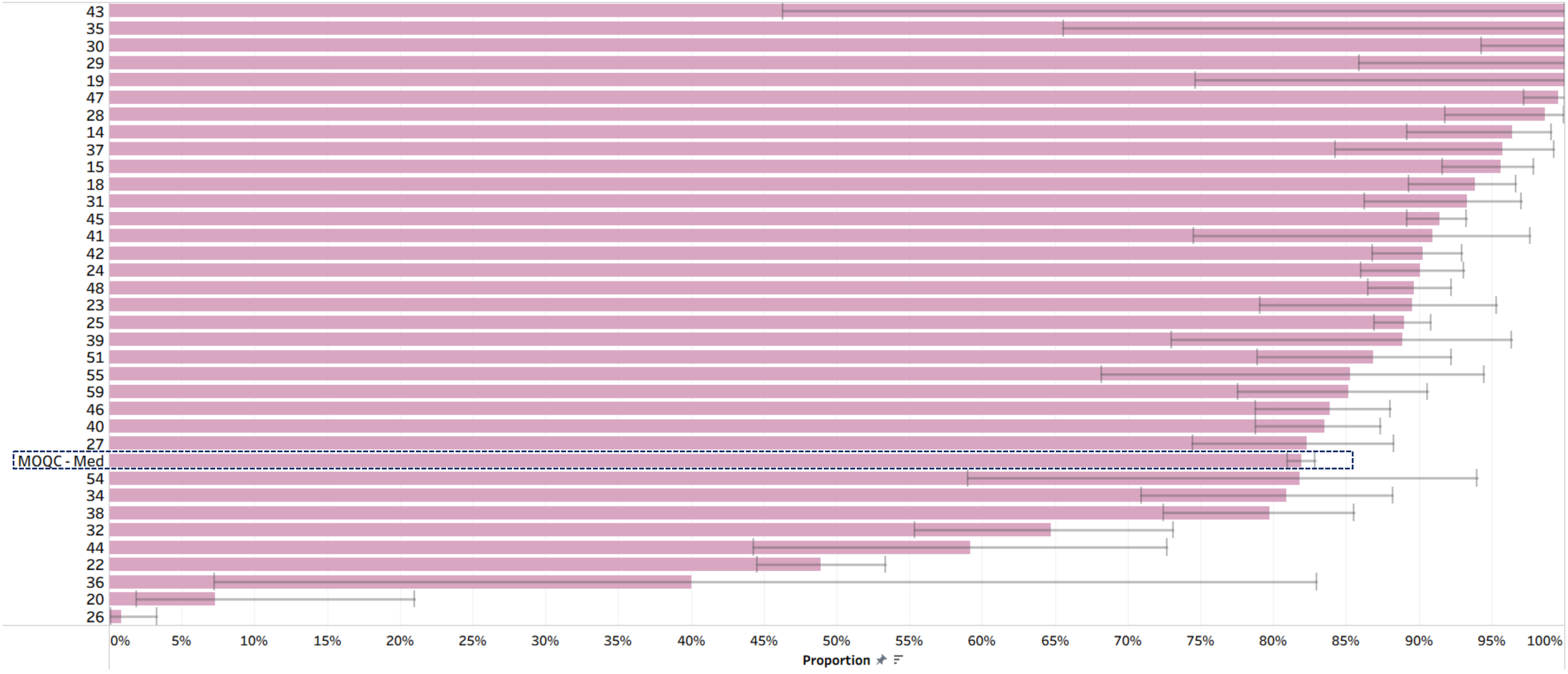
*Round 1 2026 data is through 5/15/2026. The abstraction round ends on 6/30/2026, so this number may change by the end of the round.

Color Legend

- MOQC Performance
- Target

141: Screening for Unmet Non-Medical Needs at Least Once Per Year

7/1/25 - 5/15/26, n = 6,431



Performance Compared to Prior Year

No Significant Change

Looking to Improve Non-Medical Needs Screening?

If your practice:

- Does not currently screen for non-medical needs
- Wants to strengthen connections to community resources and support services, such as MI 211

Contact MOQC*
moqc@moqc.org

*Priority given to those who respond by **July 17**

Takeaways

MOQC
MICHIGAN ONCOLOGY QUALITY CONSORTIUM

Successes

- MOQC and many practices have improved in complete family history (108a) from the previous year
- Performance for olanzapine on high emetic risk chemo (115) improved for MOQC
- MOQC has had significant improvement in early palliative care consultation (129), meeting the target
- Baseline data collection for screening for unmet non-medical needs (141) shows strong performance

Opportunities for Improvement

- Performance for tobacco cessation (101b) has been only stable
- Designated patient advocate worsened slightly from prior year but has been steady over the last 3 rounds

End-of-Life Measures

- Hospice enrollment
- Median days on hospice
- Anticancer therapy administration
- New anticancer regimen

Practices with fewer than 5 eligible cases per measure are not displayed.

Chart Selection Criteria

Chart Selection Criteria for Presented Data

Abstracted January 1, 2025 – June 30, 2026

Eligible Patient Criteria
18 or older at diagnosis
Invasive malignancy or hematologic malignancy*

EOL patients only need to meet criteria below:
Patient must have died 12/1/2023 – 5/31/2026
Patient must have a known date of death
Death related to cancer or cancer-related treatment
2 office visits (practitioner): Within 12 months preceding death

*Hematologic malignancies excluded from measures 126a, 126d, 127a, 130

MEQC

VBR

126a: Hospice Enrollment
5/16/25 - 5/15/26, n = 2,778

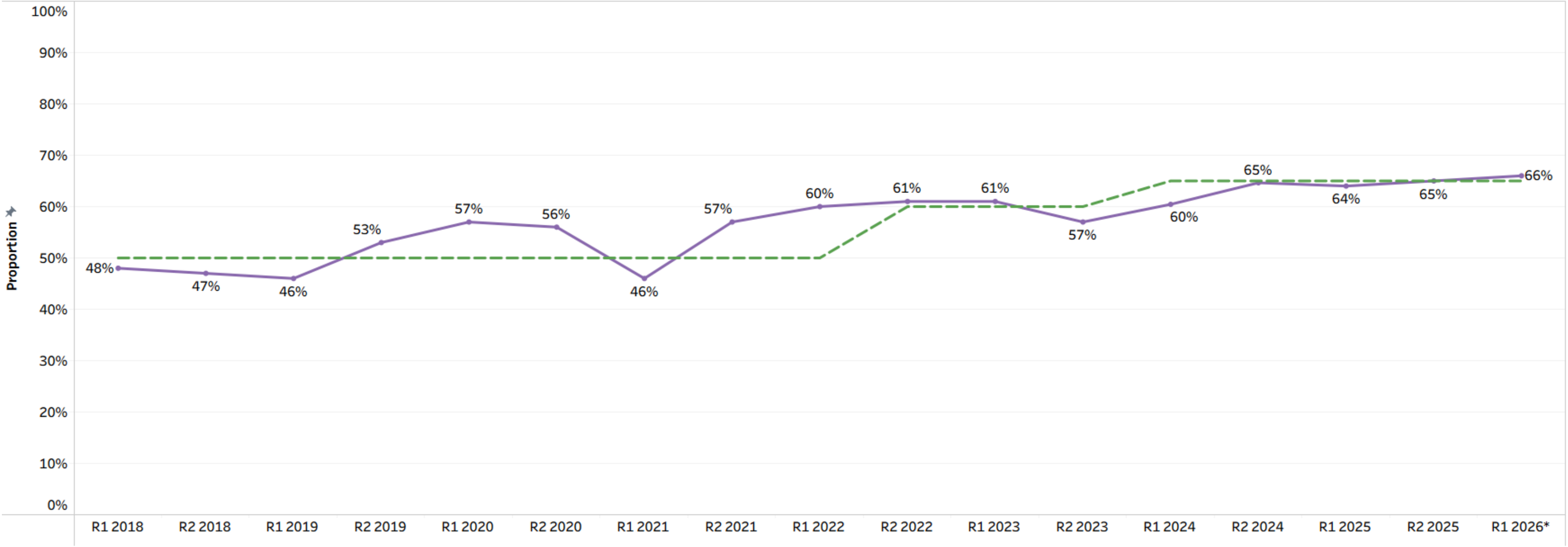
Patients with hematologic malignancies excluded.

Performance Compared to Prior Year
- No Significant Change
- Improved

MEQC

VBR

126a: Hospice Enrollment



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Color Legend

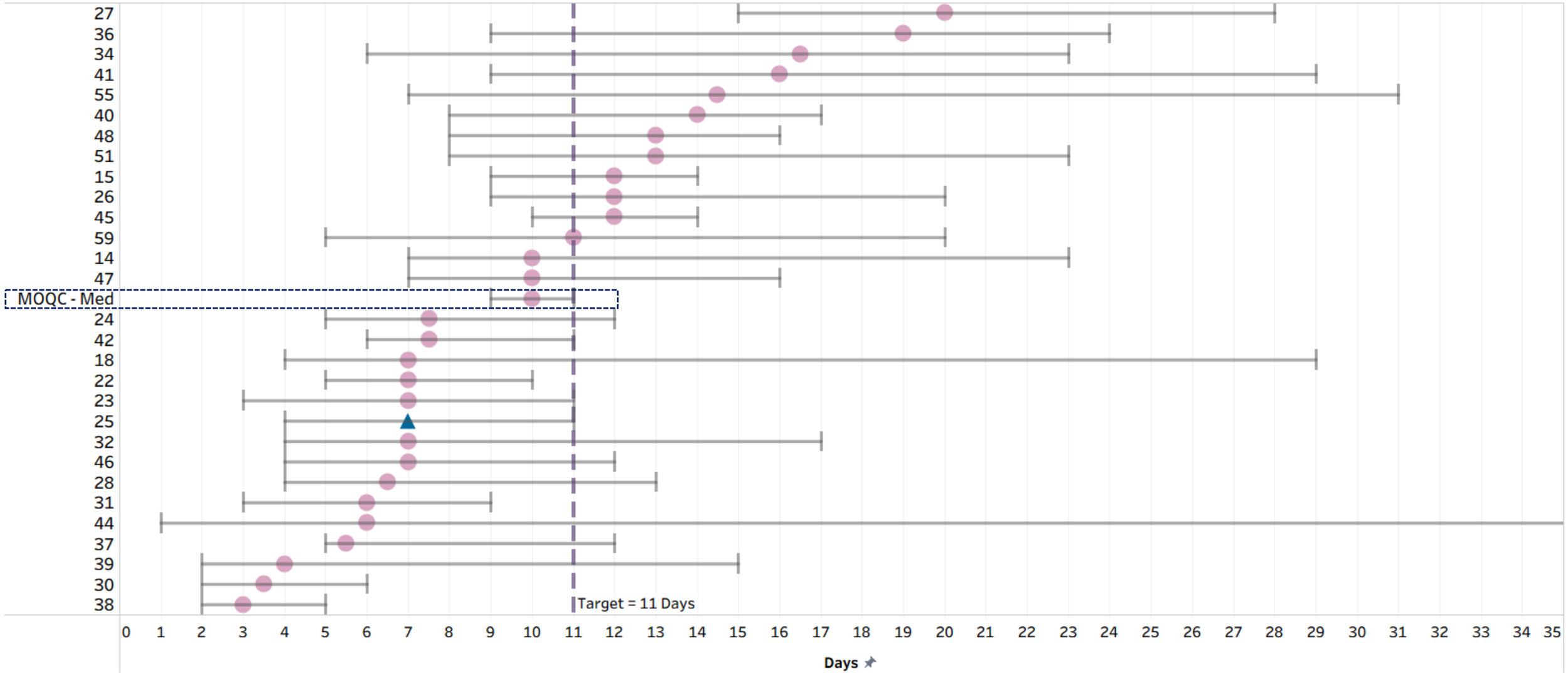
- MOQC Performance
- Target

MEQC

VBR

126d: Median Days on Hospice

5/16/25 - 5/15/26, n = 1,626



Patients with hematologic malignancies excluded.

Performance Compared to Prior Year

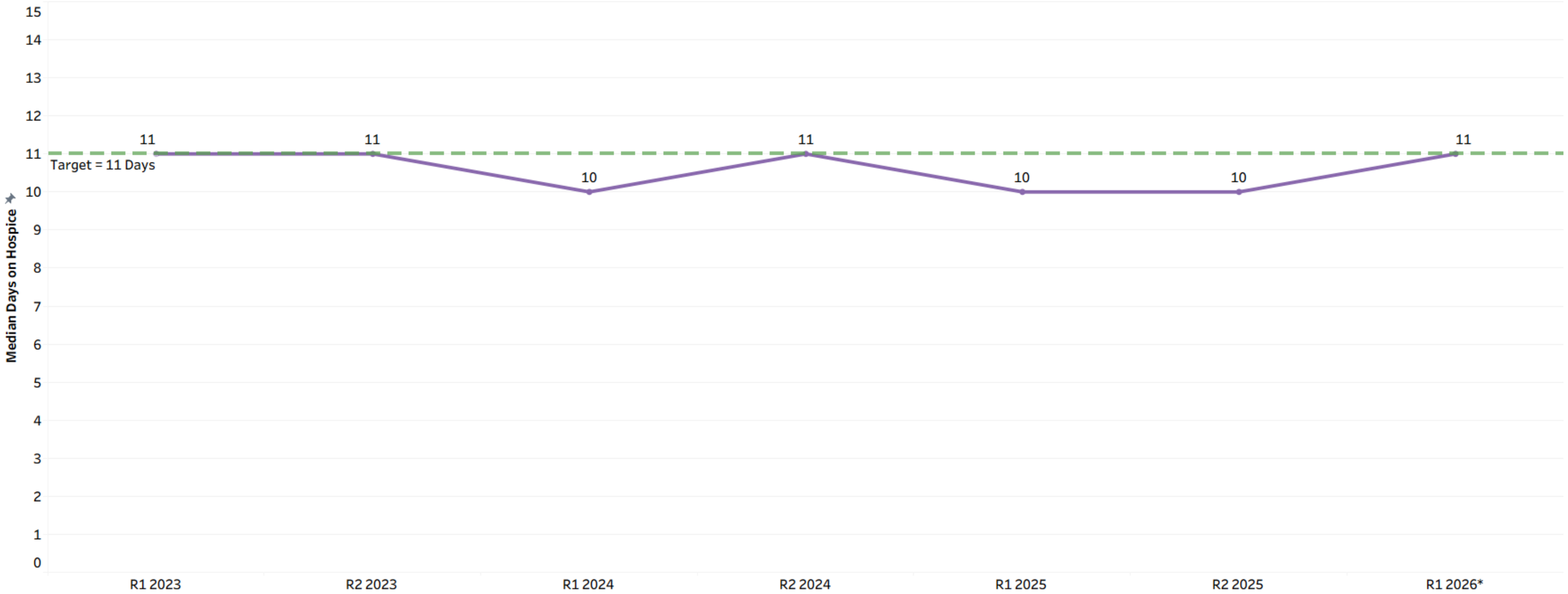
No Significant Change

Improved

MEQC

VBR

126d: Median Days on Hospice by Round



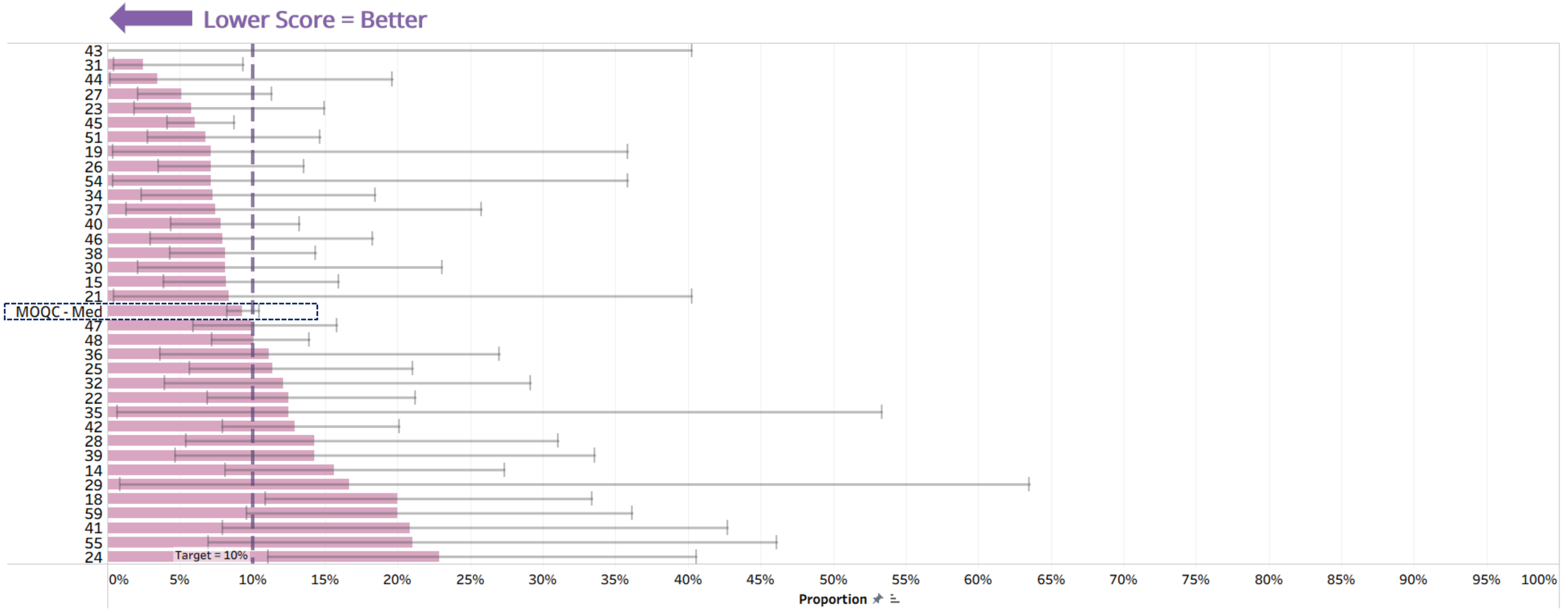
*Round 1 2026 data is through 5/15/2026. The abstraction round ends on 6/30/2026, so this number may change by the end of the round.

Color Legend

MOQC Performance

Target

127a: Any Anticancer Therapy, Including Chemotherapy, Administered within the Last 14 Days of Life
5/16/25 - 5/15/26, n = 2,804

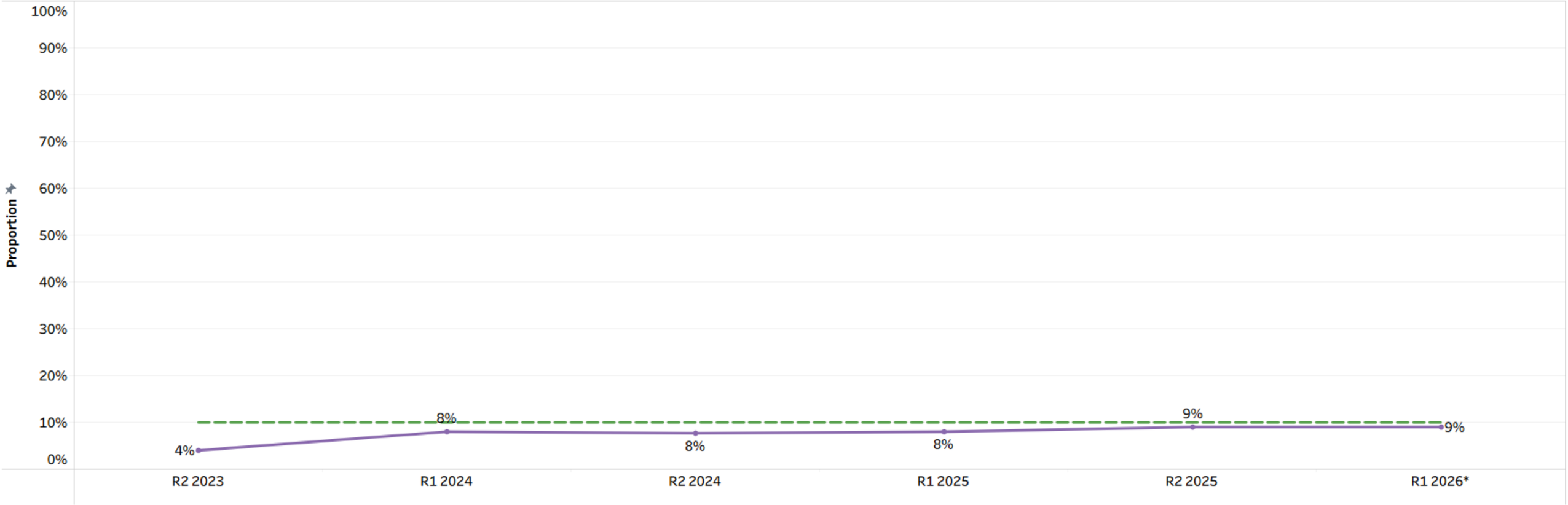


Patients with hematologic malignancies excluded.

Performance Compared to Prior Year

No Significant Change

127a: Any Anticancer Therapy, Including Chemotherapy, Administered within the Last 14 Days of Life (Lower Score = Better)



*Round 1 2026 data is through 5/15/2026. The abstraction round ends on 6/30/2026, so this number may change by the end of the round.

Color Legend

- MOQC Performance
- Target

Poll

A 72-year-old man with metastatic pancreatic cancer is hospitalized. His oncologist is considering one more cycle of chemotherapy.

What do large national studies tell us about cancer treatment given during the last month of life?

A. It reduces overall healthcare costs and shortens hospital stays.

B. It is associated with more ED visits, more hospitalizations, less hospice use, and no improvement in quality of life.

C. It improves quality of life for patients with poorer performance status.

D. Drug costs account for most of the difference in end-of-life spending.

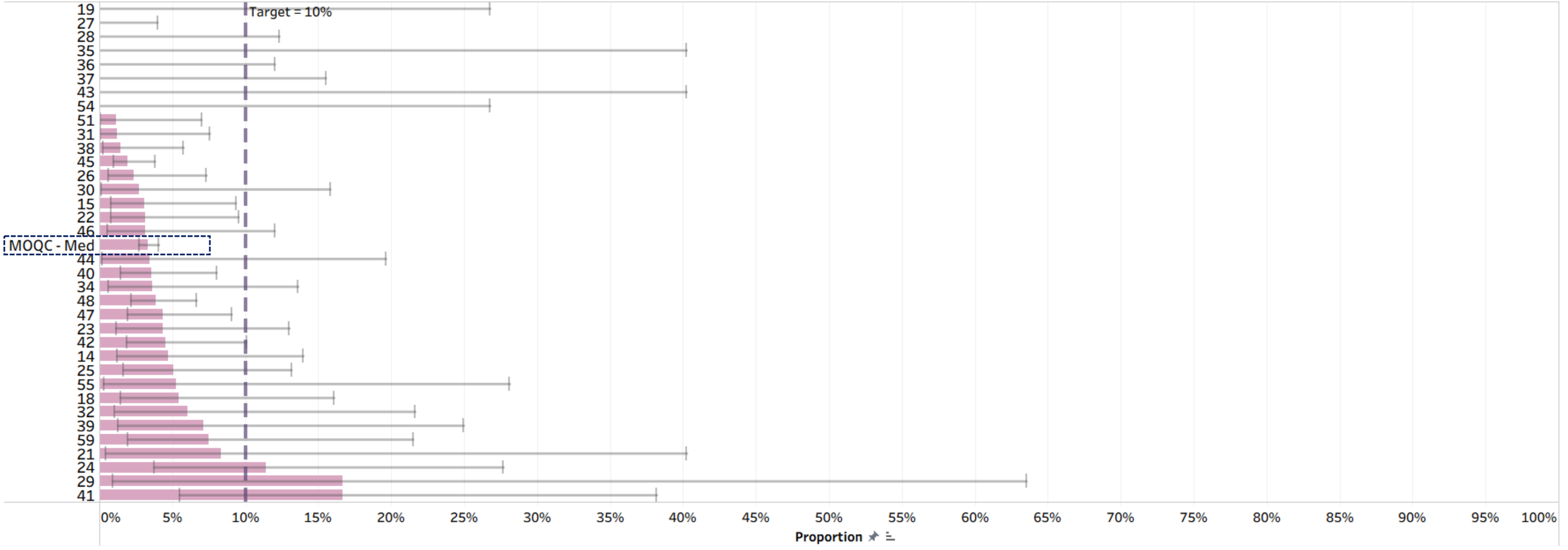
Answer

B. It is associated with more ED visits, more hospitalizations, less hospice use, and no improvement in quality of life.

Adelson et al. JCO 2024

130: Beginning a New Anticancer Regimen within the Last 14 Days of Life
5/16/25 - 5/15/26, n = 2,804

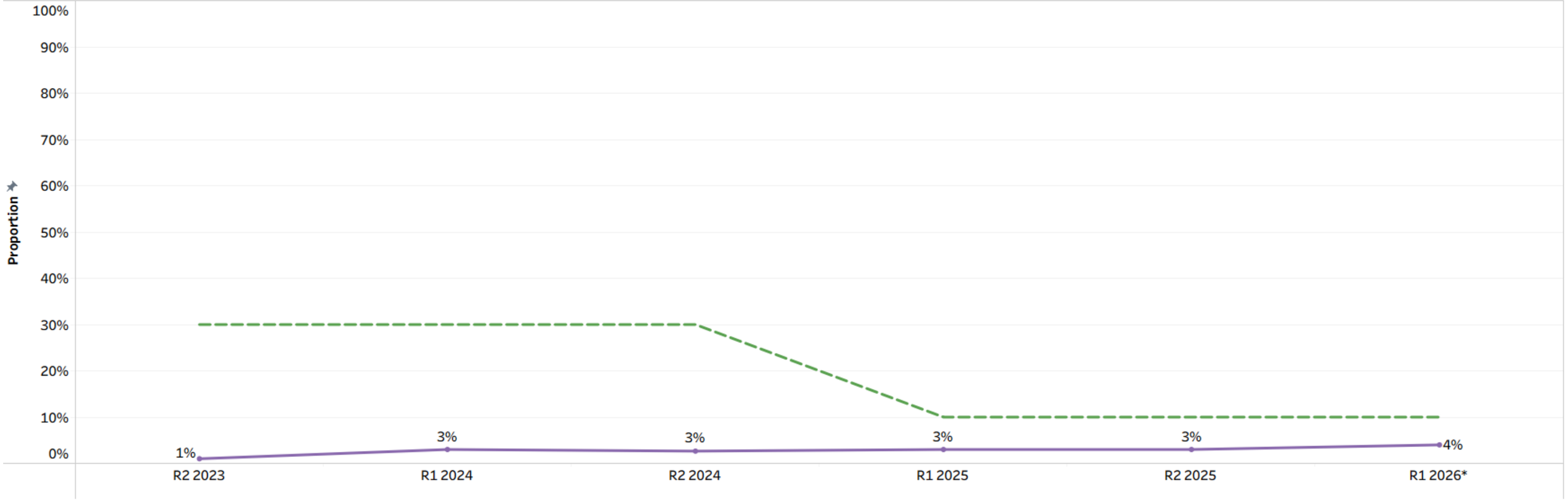
Lower Score = Better



Patients with hematologic malignancies excluded.
Patients receiving a new anticancer drug/regimen as part of a clinical trial excluded.

Performance Compared to Prior Year
No Significant Change

130: Beginning a New Anticancer Regimen within the Last 14 Days of Life
(Lower Score = Better)



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Color Legend
- MOQC Performance
- Target

Poll

If you could choose just one strategy to improve end-of-life care for patients with advanced cancer, which approach has the strongest evidence behind it?

A. Discussing prognosis during goals-of-care conversations

B. Completing advance care planning at any point, even in the final month of life

C. Involving specialty palliative care 3–6 months before death

D. Delaying palliative care until life expectancy is less than 3 months

Answer

C. Involving specialty palliative care 3–6 months before death

Mah et al. JAMA Network Open, 2024

Takeaways

MOQC
MICHIGAN ONCOLOGY QUALITY CONSORTIUM

Successes

- Hospice enrollment (126a) is meeting the target for MOQC
- No practice had a decline in performance compared to prior year
- MOQC is meeting targets for anticancer agents administered at end of life (127a)

Opportunities for Improvement

- Length of stay on hospice is biggest opportunity; national performance varies between 9 and 20 days

MOQC
MICHIGAN ONCOLOGY QUALITY CONSORTIUM

Closing

Keli DeVries, LMSW

Gynecologic Oncology Tumor Board

Last Wednesday of the month
7:30am-8:30am

Registration QR

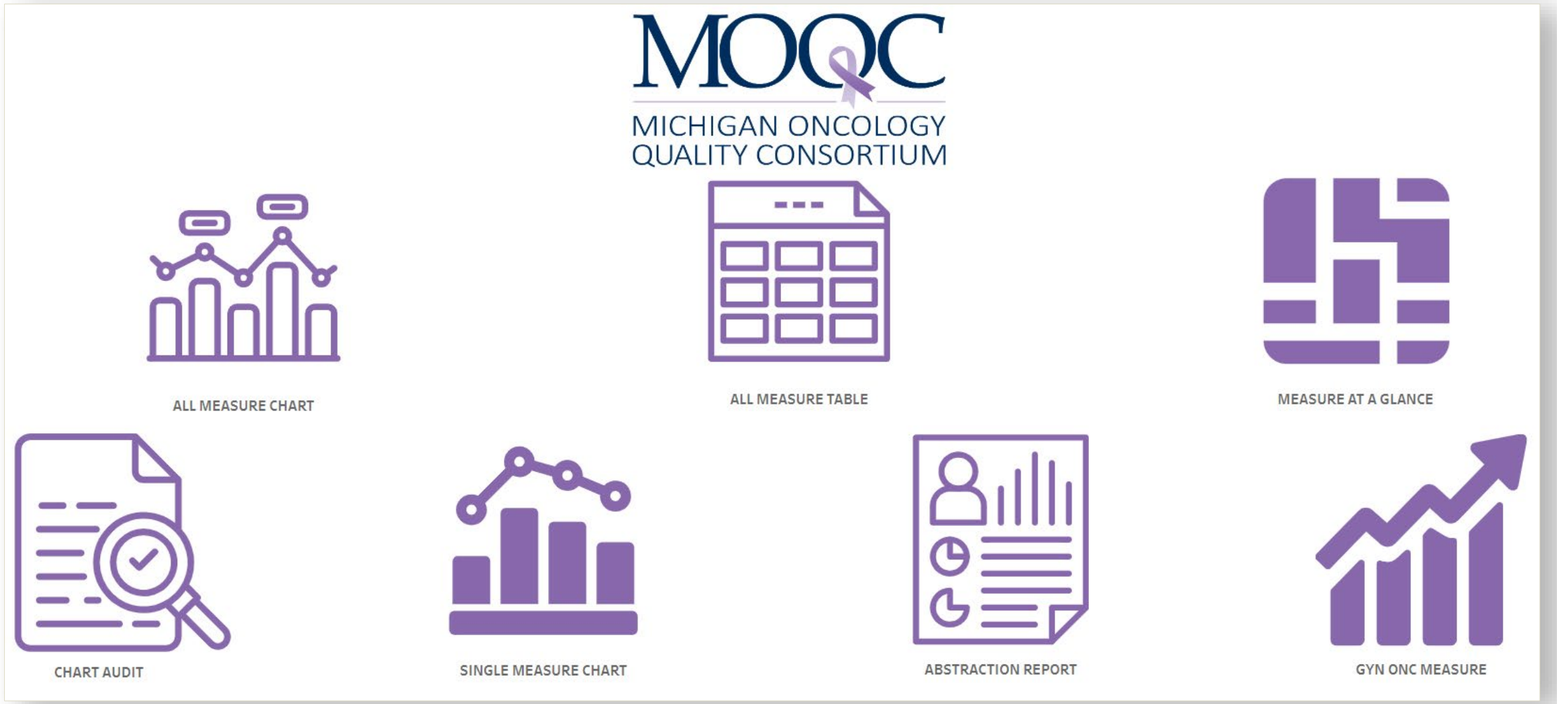
- Multidisciplinary statewide virtual forum
- Complex gynecologic oncology cases
- Collaborative learning
- Evidence-based decision making
- Shared expertise across institutions and regions of Michigan

Upcoming Meetings

Medical Oncology Regional Dinner Meetings	2026 Dates 6:00-8:00p Fall	Locations
Superior – East	**October 7,** Wednesday	Petoskey
Superior – West	**October 8,** Thursday	Marquette
Central Michigan (CMG)	**October 19,** Monday	Midland
Metro East (ME)	**October 21,** Wednesday	Troy
Lake Michigan Oncology (LMOR)	**October 26,** Monday	Grand Rapids
West of Woodward (WOW)	**October 28,** Wednesday	Novi

MOQC Dashboards

- Breakdown by
  - Practice
  - Site
  - Measure
  - Time/round



To request a dashboard account contact moqc@moqc.org

THANK YOU