Gynecology-Oncology Initiative

8:00 - 9:45am
Amway Plaza, Grand Rapids
June 22, 2018
<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 – 8:20 am</td>
<td>Registration &amp; Coffee</td>
<td></td>
</tr>
<tr>
<td>8:20 – 8:30 am</td>
<td>Welcome</td>
<td>Shitanshu Uppal, MD</td>
</tr>
<tr>
<td>8:30 – 9:00 a.m.</td>
<td>Operative Report Template</td>
<td>Barry Rosen, MD</td>
</tr>
<tr>
<td>9:00 – 9:30 a.m.</td>
<td>Enhanced Recovery After Surgery (ERAS)</td>
<td>Joseph Meunier, MD</td>
</tr>
<tr>
<td>9:30 – 9:45 a.m.</td>
<td>Direction of the Initiative and Brainstorming</td>
<td>Group</td>
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</tbody>
</table>
Re-Cap: Gynecology Oncology Initiative

Ovarian Cancer:
- Registry to monitor short & long-term outcomes
- Underlying layer for homegrown region multi-centric clinical trials
- Funding opportunities (sample size)
- Studies with patient reported outcomes

Endometrial Cancer:
- Sentinel Lymph nodes (SLN)
  - Dr. Rabbi Hanna (HFH)
  - Registry SLN outcomes
- Outcomes of type II cancers

Cervical Cancer:
- Access to care
- Adherence to guideline based care
- Access to fertility sparing options
- Radical Hysterectomy Debate
Progress to Date

17 practices

10 MOQC agreements

8 practices abstracted
Round 1

2 practices in process with QOPI

5 practices in process with MOQC

5 practices in process with QOPI

2 practices TBD

10 practices to abstract in Round 2

5 practices in process with QOPI

5 practices in process with MOQC

2 practices in process with QOPI

10 practices to abstract in Round 2

Round 1 2018 (completed)

Round 2 2018 (July, 2018)
Challenges in Data Collection

Based on our Abstractor’s Feedback

• Stage
• Residual Disease Status
• Pain Management
• Genetic Counselling/Testing Status
Note Checklist

• Pain*
  • Score [ ]
  • Treatment plan [ ]
  • Follow-up plan [ ]
• Document performance status [ ]
• Consent for chemotherapy (Including oral agents) [ ]
• Tobacco cessation*: Document current smoking status and tobacco cessation counseling if patient is a current smoker [ ]
• Infertility risk discussion - prior to anti-neoplastic treatment with patients of reproductive age [ ]
• Do not prescribe Aprepitant/Fosaprepitant or Netupitant with Cycle 1 of low or moderate emetic risk chemotherapy. (Carboplatin > AUC 4 is highly emetogenic) [ ]
• Dyspnea addressed appropriately. Or document, no shortness of breath [ ]
• Consider documenting goals of care in all patient (Curative/Palliative/Symptom Control) [ ]
  • Consider hospice enrollment when appropriate
  • Document discussion regarding hospice, palliative care referral/service*
• Document residual disease status and stage in patient’s clinic note [ ]
• Chemotherapy: Platinum and Taxane administered within 28 days following cytoreduction (or staging surgery) to women with invasive stage I (grade 3), IC-IV ovarian, fallopian tube, or primary peritoneal cancer
### Demographics

**Adding new REDCap Unique ID 2**

**REDCap Unique ID**

| REDCap Unique ID | 2 |

**Inclusion Criteria:**

1. Age >18 and Age < 90
2. Squamous Cell Carcinoma or Adenocarcinoma or Adenosquamous Carcinoma
3. Radical hysterectomy (Open or laparoscopic or Robotic)
4. Date of procedure between Jan 1st, 2010 and Dec 31, 2017

**Exclusion Criteria:**

1. Atypical histology like neuroendocrine tumors
2. Fertility sparing procedures like radical trachelectomy
3. Vaginal radical hysterectomy or vaginal assisted radical hysterectomy
4. Chemotherapy or radiation prior to surgery

**Site**

<table>
<thead>
<tr>
<th>Site</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Month of Birth**

* must provide value

**Year of Birth**

* must provide value

**Race**

- white or caucasian
- black or african american
- asian
- american indian or alaska native
- native hawaiian or pacific islander
- other
- unknown
Operative Report Template

MOQC Meeting

June 22 2018

Barry Rosen MD
History

• Started with tumor banking

• Missing clinical data, to get that data: time consuming, costly

• We started with paper database transferred to Excel

• When reviewed the charts were missing information we wanted

• Interpreting information, looking at multiple sources for 1 item

• OR reports did not include important information despite being dictated by experts
Data Collection at Point of Care

• Brilliant concept,

• Accuracy of data is better

• Comprehensive data

• Two essential components for research, outcome data, and quality
How to do it?

• Dictated notes are already in EMR

• How could we extract the data we wanted from the notes and save it to a database without doing it twice, once for the EMR and once for the database?

• Eliminate paper records
Synoptic OR reporting

- Urology started a process called synoptic OR reporting for cystoscopy

- OR report was constructed in the patient’s EMR with both
  - OR note in prose for EMR
  - Data, at the same time, saved to an oracle data base
Information automatically downloaded

Ovarian OR Note
Pre-op Assessment and OR
Items you will want in note

Ovarian OR Note
Pre-op Assessment
Ovarian OR Note

- Surgical safety checklist completed: No
- ASA score: 3 - Severe systemic disease (that limits activity)
- ECOG score: 0 - Fully active, able to carry on all pre-disease performance without restriction
- Patient position: Supine
- Exam under anesthesia: No
- EUA findings were: Abnormal
- Surgical approach: Laparoscopy
- Insufflation of the peritoneum: No
- Camera placement: No
- Port placement: No
- Ascites was found: No
- Peritoneal washings sent for cytology: No

PRE-OP ASSESSMENT:
Surgical purpose: Primary surgery.
Pre-op height: 172 cm; Pre-op weight: 67 kg; BMI: 22.65
Pre-op lab values: CA 125 is 34 U/ml; CA 19-9 is 67
She has no pre-op imaging results.

OPERATIVE NOTE:
Peri-operative antibiotics given.
ASA score: 3 - Severe systemic disease (that limits activity).
ECOG score: 0 - Fully active, able to carry on all pre-disease performance without restriction.
Patient was placed in the supine position.
Exam under anesthesia

Surgical approach: Laparoscopy
**Procedures**

**Procedure:** Total abdominal hysterectomy with bilateral salpingo-oophorectomy

**Describe procedure:** A total hysterectomy was completed. The round ligaments were clamped, transected and ligated and the ureters were identified bilaterally after opening the pararectal and paravesical spaces. The infundibulopelvic ligaments were clamped, transected and ligated bilaterally. The bladder was dissected off the anterior wall of the uterus, cervix and vagina and the uterine arteries were clamped, cut and ligated bilaterally. The uterosacral and cardinal ligaments were then clamped cut and ligated bilaterally. The vaginal angles were clamped and ligated bilaterally and the uterus, cervix and bilateral tubes and ovaries were removed and sent for routine pathology. The vagina was closed and there was adequate hemostasis.

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**MOQC**

**Michigan Oncology Quality Consortium**
Outcomes

**Intra-operative complications**
Patient had intra-operative complications: ○ Yes ○ No ×

**Gross Residual Disease**
Visible residual disease: ○ Yes ○ No ○ Unknown ×

**Largest residual tumour:**
Residual disease size: 0.1 - 1cm
Location: Left ovary, Left fallopian tube
Details: 

**Surgical Outcome**
Surgical outcome: Optimally debulked <1cm
IP portacatheter inserted: ○ Yes ○ No ○ Not available ○ Unknown ×

**Preview note:**
A total hysterectomy was completed. The round ligaments were clamped, transected and ligated and the ureters were identified bilaterally after opening the pararectal and paravesical spaces. The infundibulopelvic ligaments were clamped, transected and ligated bilaterally. The bladder was dissected off the anterior wall of the uterus, cervix and vagina and the uterine arteries were clamped, cut and ligated bilaterally. The uterosacral and cardinal ligaments were then clamped cut and ligated bilaterally. The vaginal angles were clamped and ligated bilaterally and the uterus, cervix and bilateral tubes and ovaries were removed and sent for routine pathology. The vagina was closed and there was adequate hemostasis.

Patient had no in-procedure complications.
There was visible residual disease
1. Largest residual tumour
   - Size: 0.1 - 1cm
   - Location(s): Left ovary, Left fallopian tube

Cyto-reduction outcome: Optimally debulked <1cm
### Final Details

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<tr>
<th>Estimated blood loss (cc):</th>
<th>0.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood products transfused?:</td>
<td>No</td>
</tr>
<tr>
<td>Sponge and instrument counts were correct:</td>
<td>No</td>
</tr>
<tr>
<td>Surgical specimens sent to pathology:</td>
<td>No</td>
</tr>
<tr>
<td>Were specimens sent for Tumour banking:</td>
<td>No</td>
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<tr>
<td>Intravenous fluids:</td>
<td>No</td>
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<tr>
<td>Stoma:</td>
<td>No</td>
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<tr>
<td>Camera port closure:</td>
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<tr>
<td>Fascia ports closure:</td>
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<tr>
<td>Hemostasis agent used:</td>
<td>No</td>
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<tr>
<td>Skin closure:</td>
<td>No</td>
</tr>
<tr>
<td>Post-op patient condition:</td>
<td>Unstable</td>
</tr>
</tbody>
</table>

---

**PRE-OP:**

- The uterine arteries were clamped, cut and ligated bilaterally. The uterosacral and cardinal ligaments were then clamped cut and ligated bilaterally. The vaginal angles were clamped and ligated bilaterally and the uterus, cervix and bilateral tubes and ovaries were removed and sent for routine pathology. The vagina was closed and there was adequate hemostasis.

- Procedure was completed as planned

  - Patient had no in-procedure complications.
  - There was visible residual disease.
    - Largest residual tumour
      - Size: 0.1 - 1cm
      - Location(s): Left ovary, Left fallopian tube

- Cytoreduction outcome: Optimally debulked <1cm

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**POST-OP:**

- Estimated blood loss was 0.3 mL.
- The sponge and instrument counts were correct at the end of the procedure.
- Surgical specimens were sent to pathology.
Ovarian Cancer?

- Reports were completed at point of care by attendings: **Accuracy**

- Certain variables were mandatory and others optional

- To sign off the report all mandatory fields needed to be completed: **comprehensive**
Determination of OR Variables

- Consensus

- Mandatory fields were debated (residual, CA 125)

- Accepted almost anything that was not mandatory
Value?

- Identified all Ovarian cancer patients undergoing surgery
- Downloaded to oracle database
- No chart reviews were needed
- Supported tumor banking, basic science, quality reporting, clinical research

MOQC
MICHIGAN ONCOLOGY QUALITY CONSORTIUM
## Report: pre-op assessment

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<tr>
<th>Name</th>
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<th>Overall PERCENT</th>
<th>Individual COUNT</th>
<th>Individual PERCENT</th>
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<td>Ascites found</td>
<td>Yes</td>
<td>16</td>
<td>37.21</td>
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<td>Had pre-op labs</td>
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<td>37</td>
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# Report: Intra-op findings

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<tr>
<th>Tumour Locations</th>
<th>Found?</th>
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<th>Overall PERCENT</th>
<th>Individual COUNT</th>
<th>Individual PERCENT</th>
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<td>Right pelvic sidewall peritoneum</td>
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<td>100.00</td>
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# Report: Procedures

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<th>Done?</th>
<th>Overall COUNT</th>
<th>Overall PERCENT</th>
<th>Individual COUNT</th>
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<tr>
<td>Total abdominal hysterectomy bilateral salpingo-oophorectomy</td>
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<td>53.33</td>
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<td>Bilateral salpingo-oophorectomy</td>
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<td>6.67</td>
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<td>7.69</td>
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<tr>
<td>Left salpingo-oophorectomy</td>
<td>Yes</td>
<td>1</td>
<td>2.22</td>
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<td>0</td>
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<td>Right salpingo-oophorectomy</td>
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<td>13.33</td>
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<td>Bilateral oophorectomy</td>
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<td>1</td>
<td>2.22</td>
<td>1</td>
<td>7.69</td>
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<td>Left oophorectomy</td>
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<td>4.44</td>
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<td>Appendectomy</td>
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<td>7.69</td>
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<td>Bladder peritonectomy</td>
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<td>6.67</td>
<td>1</td>
<td>7.69</td>
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<td>Pelvic peritonectomy</td>
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<td>Loop ileostomy</td>
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<td>Infracolic omentectomy</td>
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<td>73.33</td>
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<td>6.67</td>
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<td>Right diaphragm resection</td>
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</table>
The above report is based on 45 OR notes (for 45 unique patients) submitted to eCancerCare Ovarian since November 1, 2008. Report Generated on February 26, 2009.
Does Aggressive Primary Debulking Surgery Influence Outcome in Ovarian Cancer?

1. Began as a quality of care project to address differences in practice and controversies in the literature (NACT vs PDS: Aggressive vs Conventional surgery)

2. Synoptic OR note data; point of care data entry

3. We selected a homogenous group to limit bias

4. 324 stage 3C and 4 patients with high grade serous, histology 2004-2011
   145 (45%) NACT and 179 (55%) PDS
Figure 2a. Survival of death subjects by chemo type, stage 3a or 3b excluded

Probability of survival

Years after diagnosis

P < 0.0001

Neo ADJ(91/143)
ADJ (81/199)

Neo 143 128 79 44 22 12 8 4
ADJ 199 170 129 80 51 31 19 10

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Survival curves

Figure 4: Survival by extent of residual disease, primary debulking patients only, stage 3c and 4.

- 0mm residual
- 1-9mm residual
- >9mm residual
Comparison to Memorial Sloane Kettering (Chi)
Outcomes

• First time we had outcome data for ovarian cancer
## LENGTH OF SURGERY & LOS

<table>
<thead>
<tr>
<th></th>
<th>Aggressive Surgery</th>
<th>Non Aggressive Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Debulking Surgery</td>
<td>5:49 hrs</td>
<td>3:06 hrs</td>
</tr>
<tr>
<td>Neo Adjuvant Chemo</td>
<td>4:28 hrs</td>
<td>2:48 hrs</td>
</tr>
<tr>
<td>Primary Debulking Surgery</td>
<td>8.39 Days</td>
<td>6.83 Days</td>
</tr>
<tr>
<td>Neo Adjuvant Chemo</td>
<td>6.48 Days</td>
<td>4.60 Days</td>
</tr>
</tbody>
</table>
Barriers

- **Physicians:** Change? Very particular about their reports, Time

- Assumptions: medical legal, accepted by referring MD’s

- **IT:** cost, priority

- **Implementation:** Takes time
What can be done through MOQC?

- This group has already identified 8 ovarian cancer indicators for clinical notes
- Epic: templated notes
- H & P: OR notes
Clinic Note

@NAME@ was seen in follow-up of ovarian cancer.

**Performance Status**

0   Fully active no restriction  
1   Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature. E.g. Light house work, office work  
2.   Ambulatory and capable of all selfcare but unable to carry out any work activities; up and about more that 50% of waking hours  
3.   Capable of only limited selfcare; confined to bed or chair more than 50% of waking hours  
4.   Completely disabled; cannot carry on any selfcare; totally confined to bed or chair

**Surgery:** @ORDATEWBH@

**Residual disease after surgery:** No visible:  < 1 cm;  > 1 < 5 cm;  > 5 cm

**Pathology:**

**Chemotherapy:**

*Written Consent for chemotherapy*  Yes  No  
*Infertility risk discussion*  Non Applicable  Yes  No

CA 125
Review of Systems

Pain: None score?
HEENT: Neg
Chest: No SOB, no Cough
CVS: No chest pain, SOB on exertion
Abdomen. Bowel function is normal. Appetite is good. No weight loss.
GU. Bladder function is normal. No dysuria, or frequency
Gyn. No abnormalities
MSS Negative

Tobacco Cessation: NA; Yes No; Referral to tobacco cessation counseling program

Physical Exam

ASSESSMENT:
@DIAGREFRESH@

DISEASE STATUS: NED (no evidence of disease) On treatment

Goals of care discussed:
Disease and symptom free survival:
Cure:
Palliation/ palliative care options;
Hospice

PLAN:
Pain treatment:
OR Synoptic Reporting

**Procedure Details:**
She was given a general
The surgical Keystone was completed.

**Findings:**
The upper abdomen was examined by visualization and palpation

The diaphragm was clear ***
The liver was clear ***
The paracolic gutters were clear ***
The small and large bowel were clear ***
The small bowel mesentery was clear ***
The omentum was normal:***

The Pelvis was examined by visualization and palpation

The bladder peritoneum was clear ***
The right ovary: was normal:***
The left ovary was normal:***
The cul de sac was clear ***
The appendix was normal:***
There were no enlarged para aortic nodes ***
There were no enlarged pelvic nodes ***
Findings:

The spleen, pancreas, and adrenal glands are stable. There is a tiny fatty nodule in the upper pole of the cortex of the left kidney likely due to a tiny angiomyolipoma. No developing suspicious renal mass or obstructive uropathy is seen. The bladder is effaced by the enlarged heterogenous lobulated uterus with dystrophic calcifications likely due to fibroid changes.

The margins of this irregular uterus are not well separated from adjacent unopacified bowel. Unopacified bowel in the pelvis also limits evaluation of the adnexa. Diverticulosis of the colon is noted most evident distally without evidence of diverticulitis or intestinal distention. There is large amount of fecal debris throughout the entire colon. Correlate clinically for constipation.

Degenerative changes of the spine are again noted. There is again a grade 1 anterolisthesis of L3 on L4 with degenerative disc disease.
Findings

Lung Bases: Unremarkable

Abdomen
Liver: Within normal limits.
Bile Ducts: Normal caliber
Gallbladder: No calcified gallstones. Normal caliber wall.
Pancreas: Within normal limits
Spleen: Within normal limits
Adrenal Glands: Within normal limits
Kidneys: Lateral upper pole lesion measuring 11 mm with an attenuation of 75 Housefield units is identified as before without gross change given difference in technique.
Bowel: Normal caliber
Mesentery: Unremarkable. No enlarged mesenteric lymph nodes
Peritoneum: No ascites or free air. No fluid collection.
Vasculature: Within normal limits. No aortic aneurysm
Retropertioneum: Within normal limits
Abdominal Wall: Within normal limits

Pelvis: Evidence of hysterectomy. No adenopathy or masses in the pelvis. Mild presacral edema.
Urinary bladder: Within normal limits.
Bones: Degenerative changes of lumbosacral spine.
Operative Note – MOQC Quality Improvement Project
Resources

Becoming a MOQC Practice (under development)
End of Life (under development)
Fertility (under development)
Gynecology Oncology

5 Reasons To Join MOQC

LATEST NEWS
New Persistent Opioid Use Among Patients with Cancer After Curative-Intent Surgery

https://moqc.org/resources/pim-one/
Gynecology Oncology (Gyn-Onc)

Ovarian Cancer Operative Note Quality Improvement
October 2017 Kick-off Meeting of Gyn-Onc Initiative
Round 1 2018 Gyn-Onc Measures

LATEST NEWS
New Persistent Opioid Use Among Patients with Cancer After Curative-Intent Surgery

Checklist for Ovarian Cancer Operative Note Dictation

If you would like to use our operative note template generator instead – click here

Please make sure to include the following data elements in your operative note.

- **Debulking Status** – Primary vs. Interval Debulking
- **Staging Information** – If available based on imaging (for example, at least stage IIIc for a patient with a biopsy-proven lesion of the omentum) Link to ovarian cancer staging
- **Surgery Type** – Open/Robotic/Laparoscopic
- **Residual Disease Status** – Please specify if:
  - No residual disease (R0 or no visible disease)
  - Optimally debulked (1-5 mm largest visible disease)
  - Optimally debulked (6-10 mm visible disease)
  - Sub-optimally debulked (>10 mm disease residual)
    - For suboptimally debulked patients, specify the size and location of residual disease
- **Surgical Complexity Scoring** – Use the calculator below to get the score

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Choose Yes or No</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAH/BSO</td>
<td>No</td>
<td>0</td>
</tr>
</tbody>
</table>
MCCN Gynecologic Surgery Collaborative Team Summary
Sparrow Health System

Mayo Clinic Care Network
Enhanced Recovery Definition

• Enhanced Recovery is a clinical pathway and approach to surgical care that promotes the delivery of evidence-based perioperative care and reduces variability
Facing lower payment rates and potential loss of market share, [providers] have no choice but to *improve value* and be able to ‘prove it.’

M. Porter and T. Lee
“The strategy that will fix health care”
Harvard Business Review
Enhanced Recovery is…

- *Attenuation* of pathophysiologic changes occurring after surgery
- Using *alternative* strategies of management
- Replace traditional but untested practices of peri-operative care
- Primary goal: to *hasten* recovery

Kehlet H. Multimodal approach to control postoperative pathophysiology and rehabilitation. Br J Anaesth 1997;78 606-17
**Enhanced Recovery Program**

Key elements of enhanced recovery include:

- Patient and family engagement, including counseling about expectations for surgery and recovery
- State-of-the-art analgesia
- Early mobility and restoration of functional status
- Avoidance of prolonged periods of fasting
- Evidence-based best practices for preventing harms
Main Elements of Enhanced Recovery

- Euvolemia
- Early Feeding
- Pain control

(reducing opiate use overall)
MCCN ERP Experience

Value in MCCN Gynecologic Surgery Collaborative

• Initial Visit to Rochester
  • Transparency and sharing regarding Mayo’s current program
  • Education regarding process change and sustainability
  • Networking with other hospitals in the collaborative

• Coaching Calls

• Webinars

• Ability to email and ask questions and receive responses quickly

• Sharing of tools and resources via secure website

• Experience from prior Colorectal Program to build on

• A structured and supported pro-active process is needed to implement the ERAS program in a complete and successful way
ERP for Gynecologic Surgery at Sparrow

• First patients March 2017
  • Started with two surgeons (Dr. Meunier and Dr. Moyer-Brailean)
• Early patient engagement including:
  • Education, nutrition, mobility, medical optimization, carbohydrate load, DVT prophylaxis
• Standardized pre-op orders
  • Surgical and Anesthesia (multimodal analgesia)
ERP for Gynecologic Surgery at Sparrow Continued

• Standardized intra-op care
  • Surgical and Anesthesia
  • Infiltration with Bupivacaine by surgeon at incision site or Transversus Abdominis Plane Block for open procedures, multimodal analgesia, Goal Directed Fluid Therapy (GDFT), Normothermia, N/V prophylaxis, antibiotic prophylaxis

• Standard post-op care
  • Multimodal analgesia, no oral or nasal feeding tubes, minimal IV fluids, oral fluids, mobilization, early removal of catheter
Where are we today…

• Successes since November 2016
  • Implementation of Enhanced Recovery program within 4 months
  • Noticeable difference with GYN oncology patient LOS and satisfaction
  • Reduction in Oral Morphine Equivalent Data

• Challenges since November
  • Confusion with perioperative staff regarding similarities and differences of ERP patients
  • Metric Reporting
  • ERP patient list

• Ah-ha moments
  • Better compliance with Pre-operative hydration by giving patients Gatorade at Pre-Admission visit. Patients are told to drink on the way in for surgery.
Huddle Helper

Colorectal vs Gynecologic
Enhanced Recovery

Colorectal
- All Surgeons
- Fluids encouraged before procedure.
  - Patients given 20 oz gatorade to drink 2 hrs before procedure.
- Status Board Symbol—rocket ship
- Multimodal medications from day of surgery order set
- Intrathecal opioid (alternative option TAP block)
  - Anesthesia intrathecal order set needs to be used for 7 Neumann

Gynecologic
- Only Dr. Meunier and Dr. Moyer-Brailean
- Fluids encouraged before procedure.
  - Patients given 20 oz gatorade to drink 2 hrs before procedure.
- Status Board Symbol—rocket ship
- Multimodal medications from day of surgery order set
- Laparoscopic surgeries- Infiltration with liposomal bupivacaine by surgeon
- Laparotomies-TAP block before for scheduled or after for unscheduled.
Where we still need help…

• Preoperative education
  • Patient selection for Surgeon office education vs PAT education
    • Space and staffing concerns
  • In person vs web-based education
  • Offering more flexible scheduling for (evenings)
• Coordination and planning for patient care from pre-admission thru discharge
  • Nurse navigator position
Where we have established a “best practice”

• Identification of Patients by leveraging the EMR “rocket ship”
  • Tool that every Caregiver utilizes from scheduling to discharge
  • Used to pull Patients into our report
• Utilizing the EMR for reporting -- dashboard
Display Poster

- Displayed in Surgical services, Patient floor, Pre-admission testing
- Magnet board for ease of changing out data and projects
Stretcher/Door Tags

- Clear way to identify patients that are in the Enhanced Recovery Program
- Have a hole punch that allow it to hang from the stretcher and then on the patient door
Data Collection

• Data Collection challenging at first
  • Much was done by hand
  • OME reporting still reported manually

• Sparrow approached EPIC assigned systems analysts for help and support
  • Needed to identify which variables/data was important
  • Needed to identify how to report that information in EPIC
    • Floor staff, RNs, pharmacy –everyone charts differently which made collection unreliable
  • Systems Analysts built/wrote code/programs for specific “boxes/drop down boxes” for the information we wanted
  • Extensively trained and coached RNs and staff to document correctly using new format
Data Collection

• Once documentation became reliable and trackable, EPIC/Sparrow Analysts wrote new code/software to funnel all that data to spreadsheet and converted to easily accessible graphs.

• We did not hire new staff to do this—these were analysts already employed and working with EPIC within the hospital system.
Enhanced Recovery Dashboard
Oral Morphine Reduction of 77% for Length of Stay (Dr. Meunier)

Day of Surgery:
- Pre-ERP OME: 121
- Post ERP OME: 50

Length of Stay:
- Pre-ERP OME: 230
- Post ERP OME: 53
Mayo Clinic Data is similar

- Opioid use first 48 hours after surgery (OME)
  - NON ERP: 351
  - ERP: 69
  - ERP + LB: 37.5

- 90% reduction in opioid requirement
- 88% reduction in PCA use
- 40% free of opiates or Tramadol at 48 hours

Dr. Sean Dawdy, Oral Communication
Acknowledgement and Thank You to Mayo Clinic, MCCN
Drs Dawdy, Bakkum-Gamez and Kalogera
THANK YOU
Brainstorming

Our next steps?
MOQC meeting continues...

• Thank you!
• Pick up a cup of coffee
• Proceed downstairs to Ambassador Ballroom East
• Meeting with medical oncologists begins at 10:00am
• Keynote begins at 11:00am
• Open seating