MOQC
MICHIGAN ONCOLOGY QUALITY CONSORTIUM

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

MOQC SPRING 2026

GYNECOLOGIC ONCOLOGY BIANNUAL MEETING

Our Purpose: To further the success of interdisciplinary teams that improve the quality and value of cancer care.

While Blue Cross Blue Shield of Michigan and MOQC work collaboratively, the opinions, beliefs and viewpoints expressed by the presenters do not necessarily reflect the opinions, beliefs and viewpoints of BCBSM or any of its employees.

MICHIGAN ONCOLOGY QUALITY CONSORTIUM

Welcome

Vanessa Aron, BA, RYT

MOQC Core Values

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MICHIGAN ONCOLOGY QUALITY CONSORTIUM

TRUST & INTEGRITY

COMPASSION

GROWTH MINDSET

COLLABORATION

MOQC Strategic Objectives

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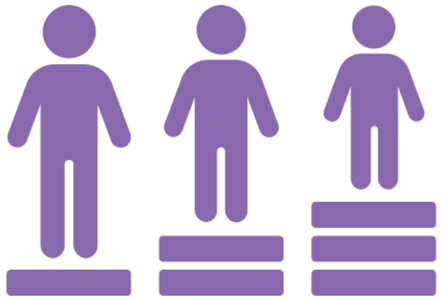


Bridging Gaps

Maximizing Value

Fostering Interprofessional Development

AGENDA

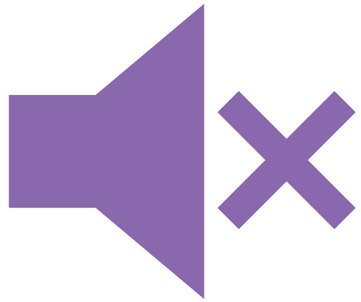
8:00 am	**Welcome and Updates**	Vanessa Aron, BA, RYT
8:25 am	**MOQC Data and Performance**	Stefany Acosta-Torres, MD
9:25am	**Break**	
9:30 am	**Voice of the Caregiver**	Jacob Sierocki, POQC
9:45 am	**Proficient or Deficient? Evolving Knowledge and Therapeutic Strategies in Advanced/Recurrent Endometrial Cancer**	Amanda Nickles Fader, MD
10:45 am	**Final MOQC Items**	Keli DeVries, LMSW
10:50 am	**Meeting Close**	

INTROS

Please
Rename
Yourself

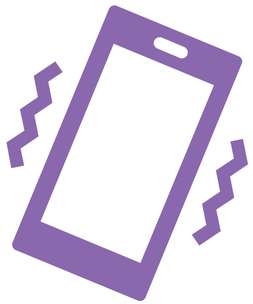
Full name • **Organization** • **Pronouns**

Reminder – How to Mute/Unmute



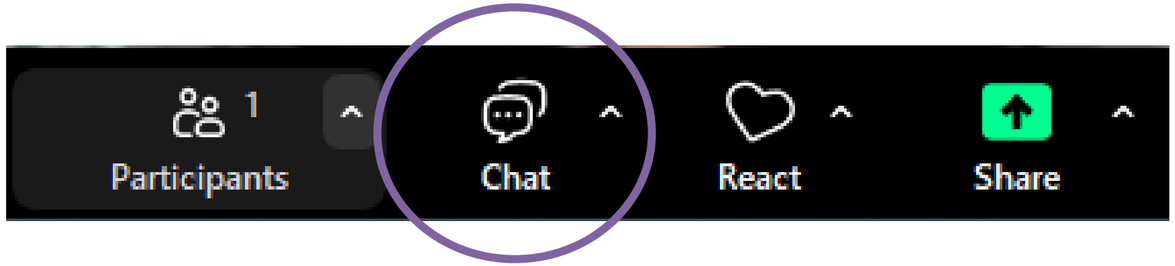
To mute your microphone

To unmute your microphone

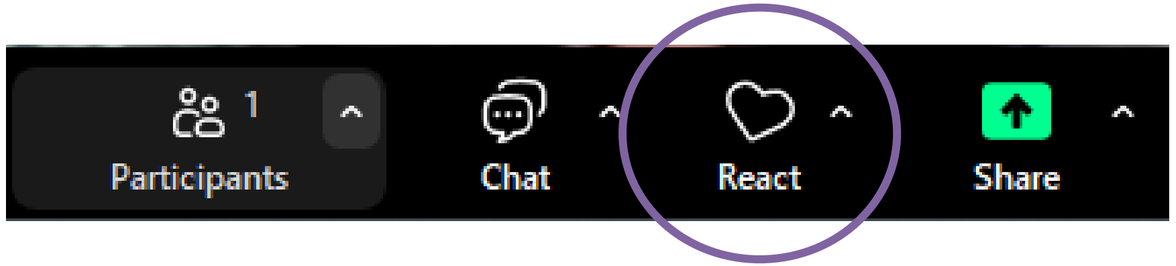


***6 to mute/unmute**

Reminder – Chat

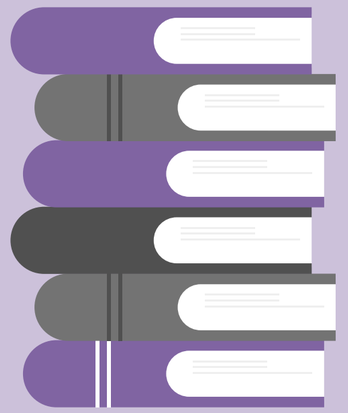


Use Chat to ask/answer questions or ask for help



Add your reactions

Confidentiality



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PHI

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Continuing Education Credits

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This meeting has been approved for a maximum of 3.00 AMA PRA Category 1 Credit(s)™.

Claiming credit must be completed within **7 days** of the live activity at *umich.cloud-cme.com*.

PATIENT & CAREGIVER ONCOLOGY QUALITY COUNCIL (POQC)

For more information on POQC, visit https://moqc.org/moqc/poqc/ or email moqc@moqc.org

Elevating Caregiver Voices

- Lived experience
- Quality improvement

Meaningful Participation

- Resource creation
- Projects and meetings

Impact on Healthcare Teams

- Accessible
- Responsive

Community and Support

- Connection
- Purpose

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2025 Achievements & Highlights

Blue Cross Blue Shield of Michigan
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Statewide Non-Medical Needs Expansion
7 Domains Screened Annually
EHR → 2-1-1 Integration

Oncology Stewardship
Statewide Biomarker Benchmarking
—— Collaborations with ——
Economic Alliance for Michigan (EAM)
Testing Coverage by Payers
Pharmacy Times Continuing Education
3 CE Modules (mNSCLC)

Financial Navigation
36 MOQC Navigators Trained
MDHHS Partnership
Partnership with Patient Advocate Foundation

Palliative Care
CAPC MOQC Certificate Program — Cohort 1
14 Clinicians Trained
7 MOQC Regions Represented

Patient-Reported Outcomes (PROs)
536 Patients Surveyed
18 Practices

Family History
38% Documentation Rate
Sustained Improvement Since 2024

Interprofessional Development
Advance Care Planning + Post-Op Healing
119 Participants
18 Practices Represented

Caregiver Navigation
- **Secured Grant** to Pilot Caregiver Navigation Training
- **Partnered with Rush to Develop Program, Launching in 2026**

Dissemination
- 4 Posters at National Meetings
  - **ASCO Quality, CAPC, JADPRO**
- Presented at **MSHIELD and MVC** Collaborative-Wide Meetings
- Exhibited at Food as Medicine Summit
- **Published Olanzapine Manuscript** May 2025 in **JAMA Network Open**

Comfort Cuisine
4,312 Meals Provided
50 Patients Supported
27 Caregivers Supported
COMFORT CUISINE

Statewide Gynecologic Oncology Tumor Board

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- **Launching today!**
- Monthly, virtual meetings
- Practices can submit cases to MOQC

Date Selection Survey

https://umich.qualtrics.com/jfe/form/SV_6r71JruElfgbkOy

Steering Committee Invite

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2025 – 12%

2026 – 15%

https://moqc.org/initiatives/clinical/meqc/

2025 Value-Based Reimbursement

GYN-Level

Meet 2 of 2

- Days from surgery to chemotherapy — 28 days
- Prescribing of opioids for patients after laparoscopic or open hysterectomy — 9 pills

3% Opportunity

Practice-Level

Meet 3 of 3

- Meet 2 of 2 GYN-Level Measures
- Complete family history documented for patients with invasive cancer — 35%

2% Opportunity

Collaborative-Level

Meet 1 of 1

- Tobacco cessation counseling administered or patient referred in past year — 75%

2% Opportunity

2026 Value-Based Reimbursement

GYN-Level

Meet 5 of 7

• Days from surgery to chemotherapy	28 days
• Prescribing of opioids for patients after laparoscopic or open hysterectomy	9 pills
• Complete family history documented for patients with invasive cancer	**40%**
• Olanzapine prescribing as part of a 4-drug antiemetic regimen with cycle 1 high emetic risk	65%
• Hospice enrollment	65%
• Median days on hospice	11 days
• Palliative care consultation more than 90 days before death	25%

5 out of 7

5% Opportunity

Collaborative-Level

Meet 1 of 1

• Tobacco cessation counseling administered or patient referred in past year	**68%**

2% Opportunity

2026 Measure Targets

Practice-Level

MEQC Measure

Total eligibility: **15%**

Collaborative-Level

VBR Measure

Total eligibility: up to **7%**

Certified MEQC practices are only eligible for the 15% VBR

2026 Participation to Qualify for Fee Schedule Increases

Other Requirements	
Physician Level	Provider must be enrolled in PGIP for at least one year
Practice Level	10 charts in the denominator per VBR measure per round *Exceptions may be made for EOL measures

Points Needed: 100		
Meeting Participation	**Points**	**Notes**
MOQC June Biannual Meeting **Physician Champion**	25	If either of the Biannual Meetings is unattended by a practice manager or physician, in order to qualify for **additional participation points**, the practice manager or physician must schedule a follow up meeting a MOQC project manager for a Biannual Meeting and practice-level overview. Additional participation points can only be used to complete the eligibility points requirement once every **two years**.
MOQC June Biannual Meeting **Administrative Champion**	25	
Gynecologic Oncology Fall Biannual Meeting **Physician Champion**	25	
Gynecologic Oncology Fall Biannual Meeting **Administrative Champion**	25	

Participation to Qualify for Fee Schedule Increases

Points Needed: 100		
Additional Participation	**Points**	**Description**
Presentation at a MOQC Biannual Meeting	40	Gynecologic oncology or medical oncology biannual meetings
MOQC Steering Committee	30	Attend and actively participate with at least 50% of the meetings within the eligibility year
MOQC Measures Committee	30	Attend and actively participate with at least 50% of the meetings within the eligibility year
Approved MOQC Task Forces or Workgroups	30	Attend and actively participate with at least 50% of the meetings within the eligibility year
Development of educational resources	20	Examples: checklist creation workgroup, clinical trials navigation tool development, podcast expert participation
Connection Visit on-site	20	Have MOQC come visit your practice!
POEM	20	Participate with a POEM pharmacist
Participation with MOQC newsletter	10	Practice spotlight interview, article about best practices, etc.
Attendance at Interprofessional Development Session	10	Attend a session of Interprofessional Development – any practice member

Data & Performance

Stefany Acosta-Torres, MD

Thank You, Data Abstractors

- Bambi McCracken, Cancer & Hematology Centers
- Jennifer Hogan, Cancer & Hematology Centers
- Ashley Poulin, Great Lakes Cancer Management
- Jodi Morrow, Great Lakes Cancer Management
- Sarah Kott, Great Lakes Cancer Management
- Julie Boylan, Hematology Oncology Consultants
- Annie Reichenbach, Hematology Oncology Consultants
- Alycia DeBord, Henry Ford Health
- Vanessa Schroeder, Henry Ford Health
- Alicia Kehoe, Huron Medical Center
- Danielle Delano, Huron Medical Center
- Stacy Lantrip, KCI Greater Lansing
- Amanda Vernier, KCI at McLaren Macomb
- Karen Matelic, Trinity Health Grand Rapids
- Shely Moul, MHP Downriver
- Blair Pease, West Michigan Cancer Center
- Amber Tucker, West Michigan Cancer Center

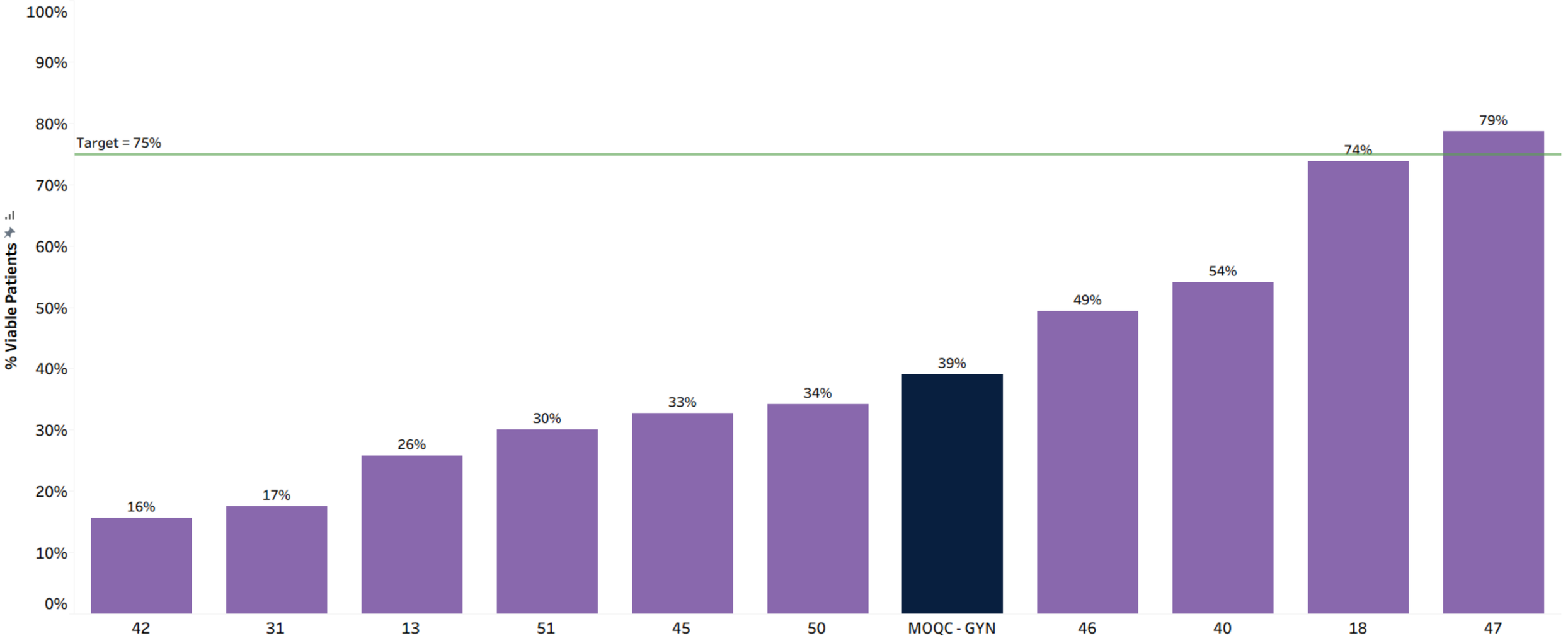
MOQC Team

Kleanthe Kolizeras, Heather Behring, Cindy Michalek, Heather Rombach, Deborah Turner, Shawn Winsted, Deana Jansa, Jennifer Broadhurst, Angie Green

MOQC by Proxy

Colleen Schwartz, Therese Hecksel, Megan Beaudrie, Jeanne Melton, Maggie Scroggin

Proportion of Patient Lists Eligible for Abstraction, Round 2 2025



Med Onc Measures

- Tobacco cessation counseling or referral
- Designated patient advocate documentation
- Complete family history
- Olanzapine as part of a 4-drug antiemetic regimen (high emetic risk chemotherapy)

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Chart Selection Criteria for Presented Data

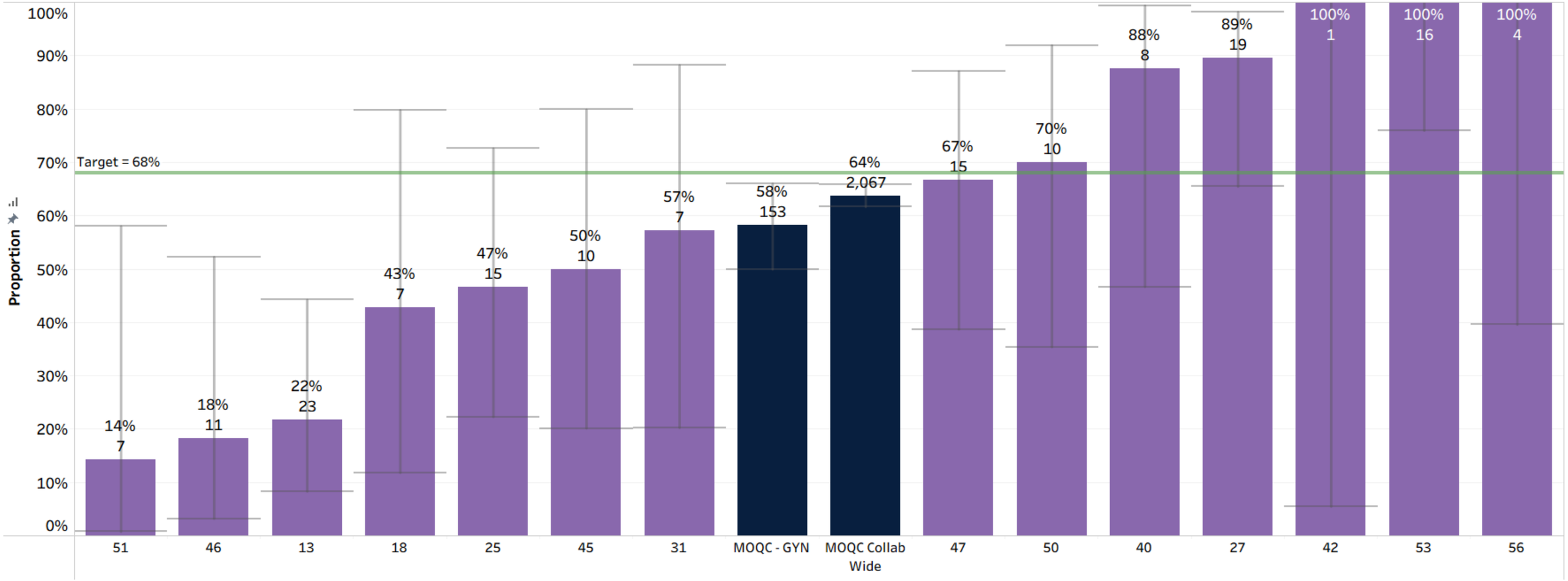
Abstracted February 1, 2025 – January 31, 2026

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

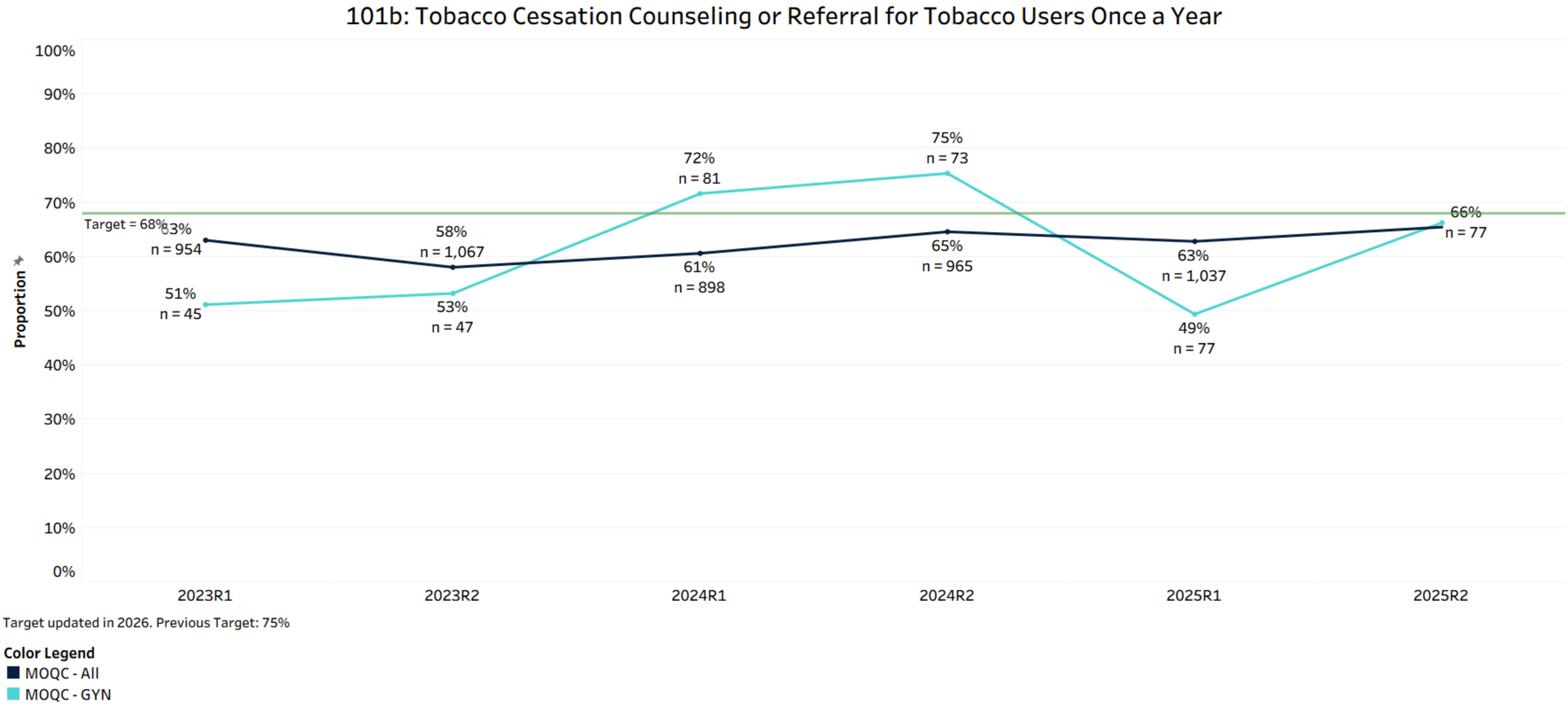
Diagnosis & Visit Window
Diagnosed: 12/1/2023 – 3/31/2026
First Office Visit: 12/1/2023 – 5/31/2026
2 Office Visits (practitioner): 10/1/2024 – 5/31/2026

VBR Measure

101b: Tobacco Cessation Counseling or Referral for Tobacco Users Once a Year
2/1/2025 - 1/31/2026, n = 153



Target updated in 2026. Previous Target: 75%



Trend slides use rounds to highlight trends over time – each round represents 6 months of calendar year data

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

Non-Clinical Interventions that Impact Survival

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Tobacco cessation: 75th percentile survival –
3.9 years (cessation) vs 2.1 years (continued smokers)

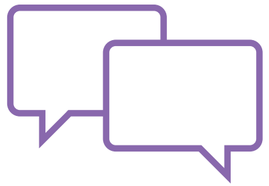

JAMA Oncology | Original Investigation

Survival Outcomes of an Early Intervention
Smoking Cessation Treatment After a Cancer Diagnosis

Paul M. Cinciripini, PhD; George Kypriotakis, PhD; Janice A. Blalock, PhD; Maher Karam-Hage, MD; Diane M. Beneventi, PhD; Jason D. Robinson, PhD; Jennifer A. Minnix, PhD; Graham W. Warren, MD, PhD

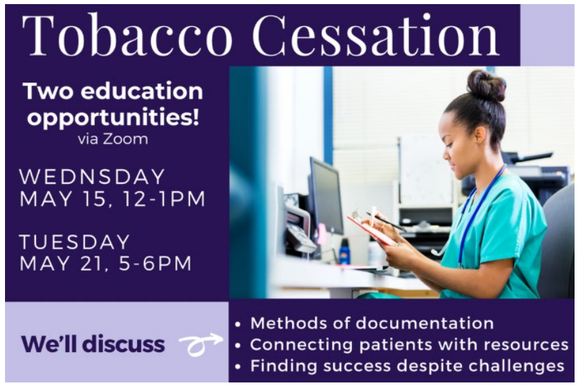
Other Interventions:

- Exercise in colorectal cancer
- Patient-reported outcomes
- Early palliative care involvement



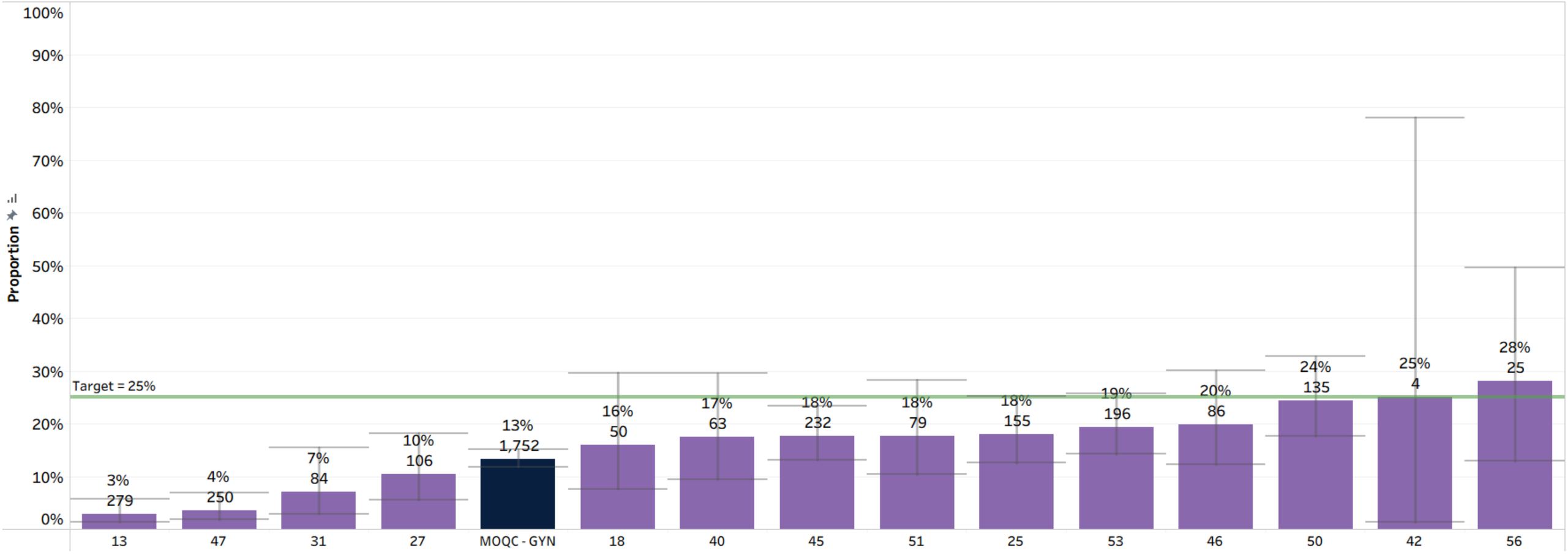
https://pubmed.ncbi.nlm.nih.gov/39480450/; https://pubmed.ncbi.nlm.nih.gov/40450658/; https://pubmed.ncbi.nlm.nih.gov/28586821/

Interprofessional Development Education Sessions can be found at https://moqc.org/eventspace/



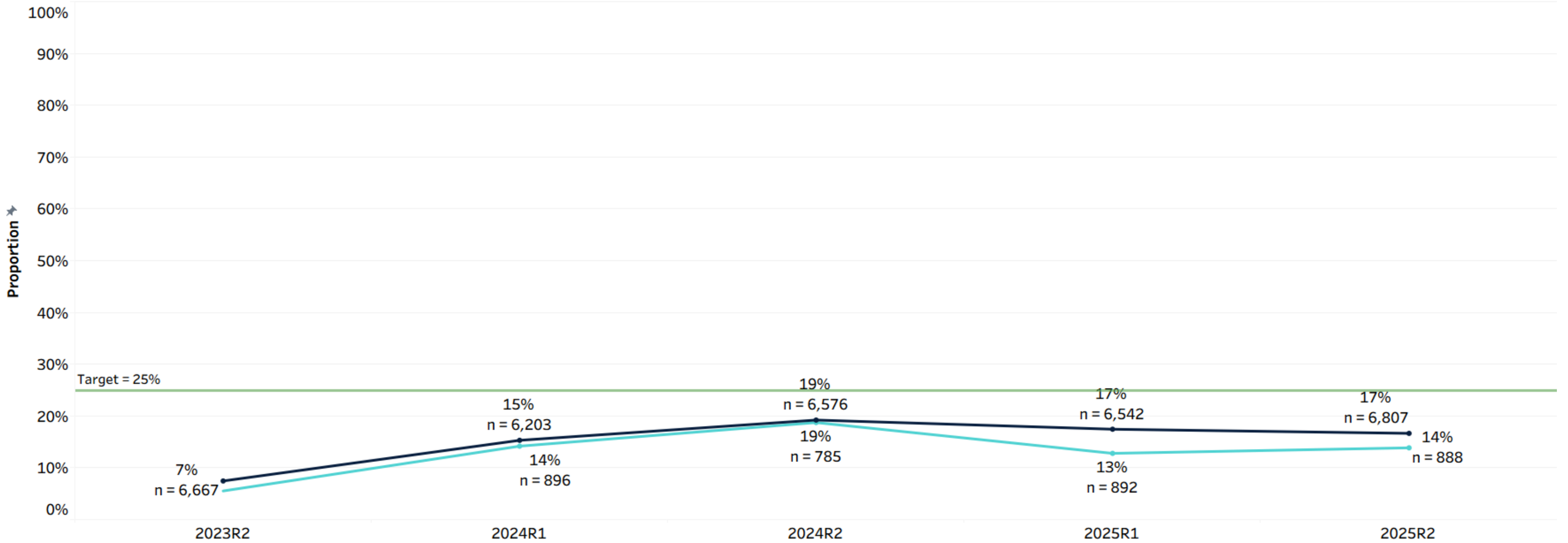
Tobacco Cessation IPD Session

103: Designated Advocate Documented on a Legally Recognized Document in the Inpatient or Outpatient Medical Record
2/1/2025 - 1/31/2026, n = 1,752



Target updated in 2026. Previous Target: 20%

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



Target updated in 2026. Previous Target: 75%

Color Legend

- MOQC - All
- MOQC - GYN

Trend slides use rounds to highlight trends over time – each round represents 6 months of calendar year data

FIVE WISHES®

MY WISH FOR:

1. The Person I Want to Make Care Decisions for Me When I Can't
2. The Kind of Medical Treatment I Want or Don't Want
3. How Comfortable I Want to Be
4. How I Want People to Treat Me
5. What I Want My Loved Ones to Know

Print Your Name

Birthdate

Understanding Health Proxies and Patient Advocates

1. **What is a Patient Advocate?**
   Someone 18 or older you **legally choose** to make **medical or mental health decisions** for you if you're **unable** to **express** your **wishes** or **needs**.
2. **Who May Be My Best Patient Advocate?**
   It **may not** always be your spouse, family, or children. Sometimes, it can be a **trusted friend** who truly understands you and will **respect** your **medical wishes**.
3. **Do I Need a Patient Advocate Only If I'm Seriously Ill?**
   No, any adult can **benefit** from having a patient advocate. This is especially **important** if you **can't make decisions** for yourself, as your patient **advocate** can **speak** and **give consent** on your behalf.
4. **Who Can Be a Witness and How Many Are Needed?**
   On your patient advocate designation form, you need **two adult witnesses** who are **not** your **family**, **doctor**, designated **advocate**, or **employees** of the **place** you **receive care**.

MiHIN Advance Directive

Five Wishes

Interprofessional Development Education Sessions can be found at https://moqc.org/eventspace/

ADVANCE CARE PLANNING

PART 1: FRIDAY, FEBRUARY 7, 12-1PM

PART 2: WEDNESDAY, FEBRUARY 12, 12-1PM

Both sessions will be held via Zoom

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Cancer care. Patients first. The best care. Everywhere.

PRESENTED BY:

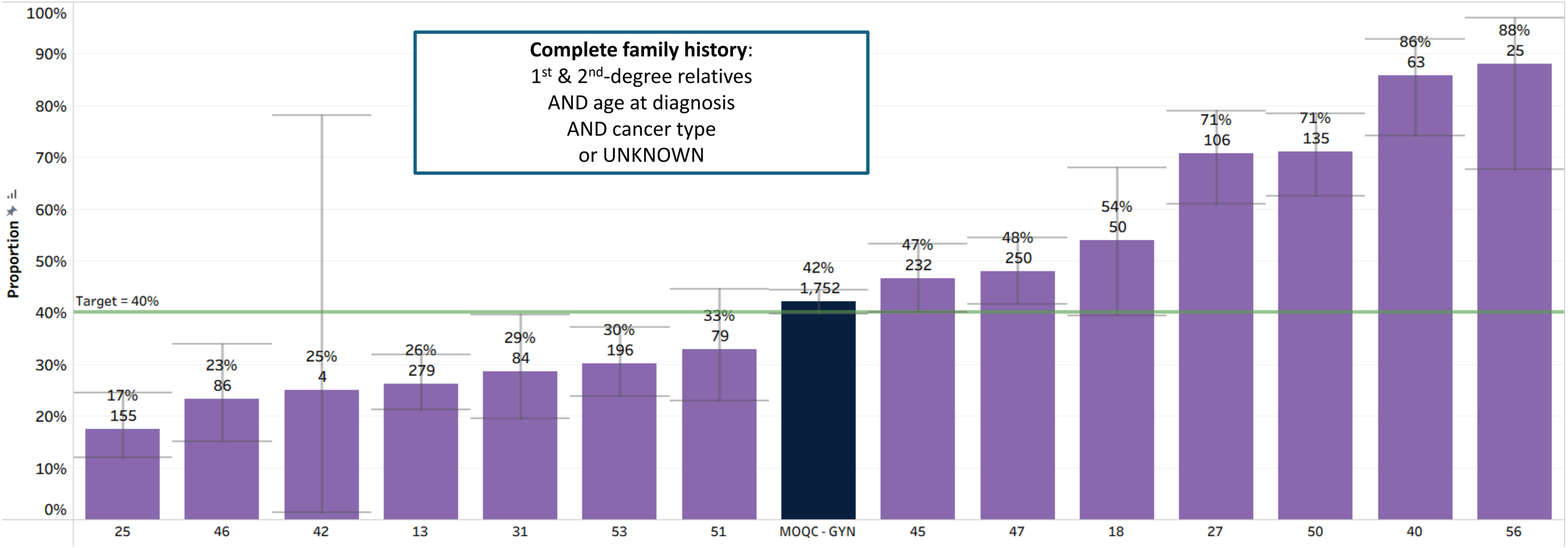
Tracy Bargeron, MSN, RN
Summer Bates, FNP-BC, ACHPN
Katie Parkhurst, RN, BSN
Covenant HealthCare

Intended audience:
All healthcare team members

MEQC Measure

VBR Measure

108a: Complete Family History Documented for Patients with Invasive Cancer
2/1/2025 - 1/31/2026, n = 1,752

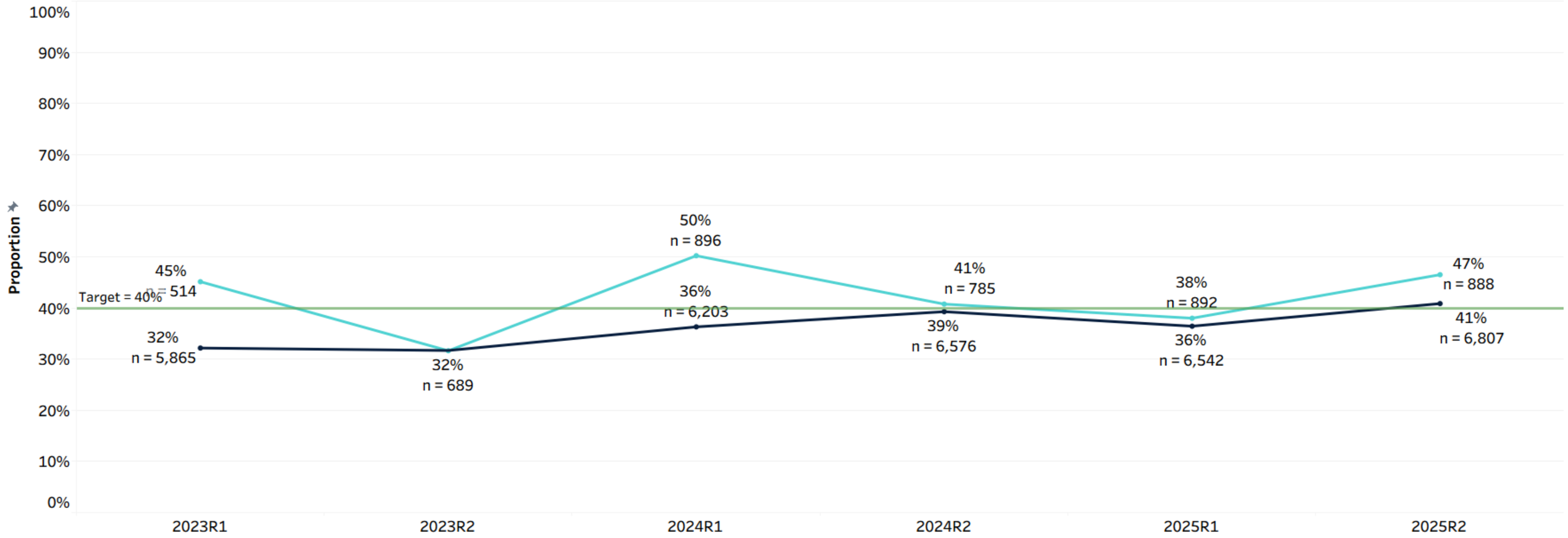


Target updated in 2026. Previous Target: 35%

MEQC Measure

VBR Measure

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



Target updated in 2026. Previous Target: 35%

Color Legend

- MOQC - All
- MOQC - GYN

Trend slides use rounds to highlight trends over time – each round represents 6 months of calendar year data

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

Created in partnership with Munson

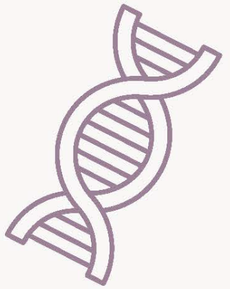
Cancer Genetic Counseling: What to Know

Cancer genetic counseling is for people who may have an increased chance of cancer due to their personal or family history of cancer. Genetic counselors are healthcare providers who can help assess if you have an increased risk of cancer by looking at your personal and family medical history. Having genetic counseling is your choice. The information below can help you decide if this is right for you.

What are some reasons I might see a cancer genetic counselor?

You might see a cancer genetic counselor if you have a personal and/or family history of cancer that suggests an inherited risk. Clues that there may be an inherited risk for cancer in a family include:

- Cancers diagnosed at an earlier age than usual (diagnosed under age 50)
- Rare cancers such as male breast cancer
- Being diagnosed with more than one type of cancer
- Multiple family members with the same or related types of cancers
- Personal or family history of a hereditary cancer syndrome such as Lynch syndrome or hereditary breast and ovarian cancer syndrome



This list does not cover every reason a person might see a cancer genetic counselor. If you are not sure about seeing a genetic counselor, ask your doctor if they think it is right for you.

What happens during a genetic counseling appointment?

You will meet with a genetic counselor and sometimes another healthcare provider, like a doctor. In this meeting, you will discuss your personal and family medical history. The genetic counselor will explain genetic testing, and review the benefits and risks to help you decide if genetic testing is right for you. The genetic counselor will assess if you are at increased risk for cancer and talk about your options for preventing cancer.

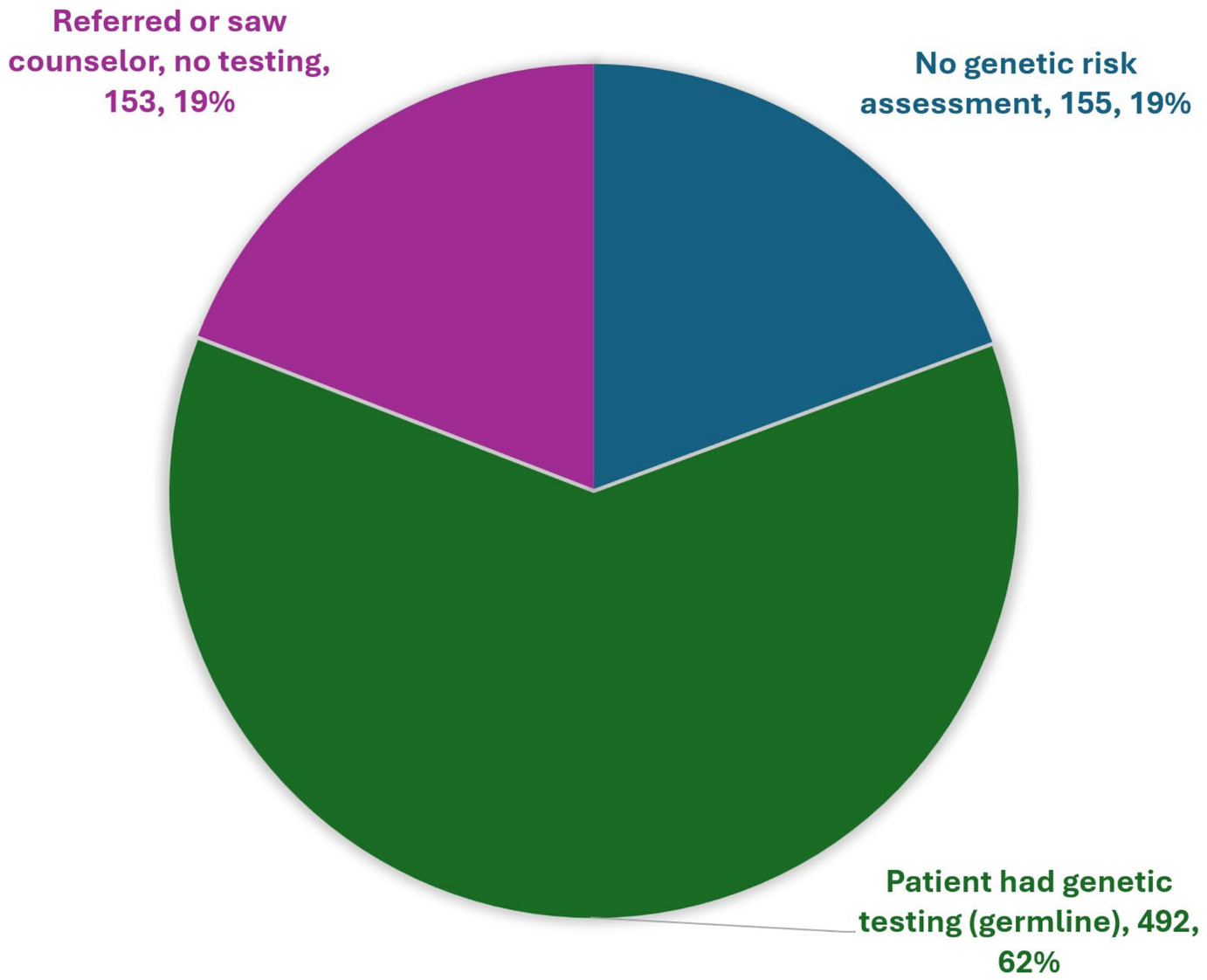
What kind of sample is used for genetic testing?

If you decide to have genetic testing, it is normally done using a blood, saliva, or cheek swab sample. In rare cases, your provider might ask for a different kind of sample.

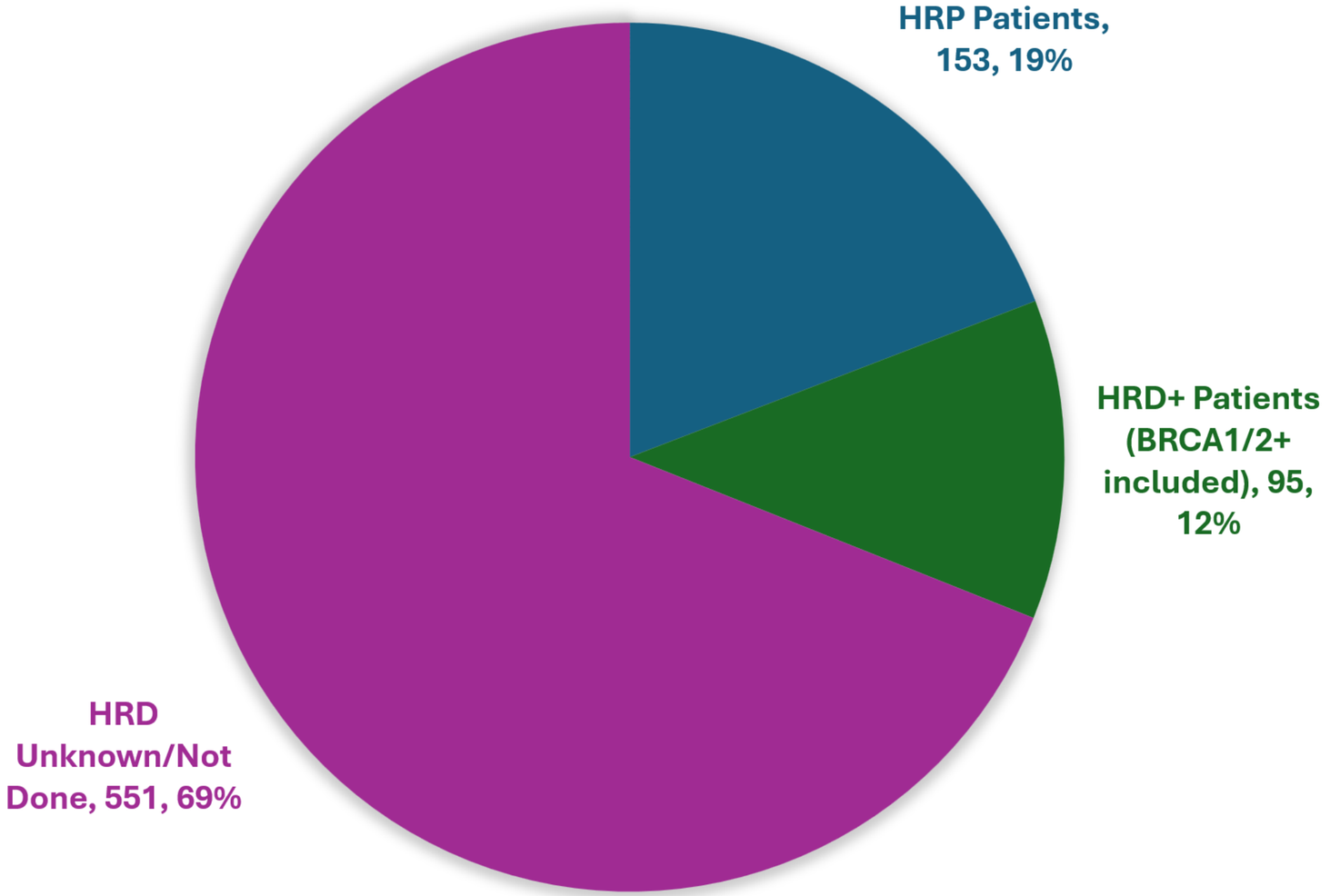
What information could I get from genetic testing?

The purpose of cancer genetic testing is to see if someone has an inherited genetic change that may put them at higher risk for some cancers. If someone has an inherited risk for cancer, there are often ways a healthcare provider can help reduce their chance for cancer or find it early. When a person has an inherited risk of cancer, this means their family may also be at risk. It is recommended to share this information with family members, but that is your choice. A genetic counselor can help you talk about this with relatives, if you are willing.

GENETIC RISK ASSESSMENT
6/1/2024 - 2/17/2026, N = 800



HRD STATUS DOCUMENTED, INCLUDING BRCA1/2+ OVARIAN, FALLOPIAN TUBE, PERITONEAL CANCER PATIENTS 6/1/2024 - 2/17/2026, N = 800

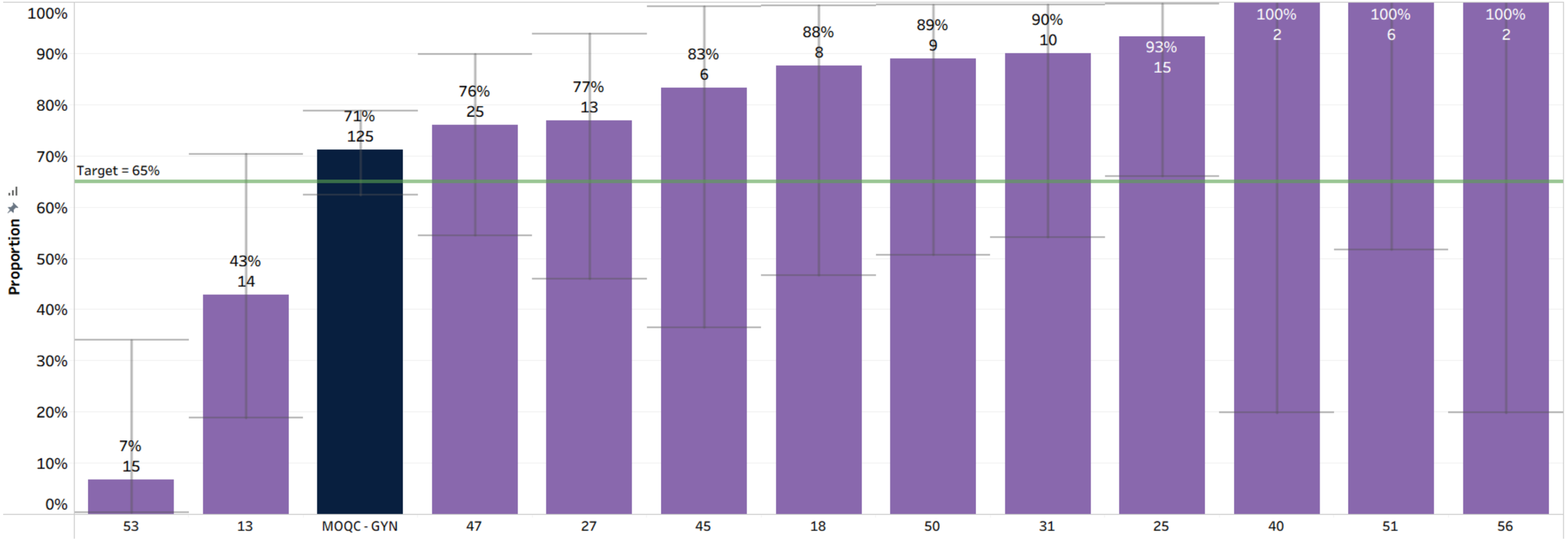


- 6 of the 153 HRP Patients received PARP Inhibitor (4%)
- 45 of the 95 HRD+ Patients received PARP Inhibitor (47%)

MEQC Measure

VBR Measure

115: Olanzapine Prescribed as Part of a 4-Drug Antiemetic Regimen with Cycle 1 High Emetic Risk Chemotherapy
2/1/2025 - 1/31/2026, n = 125



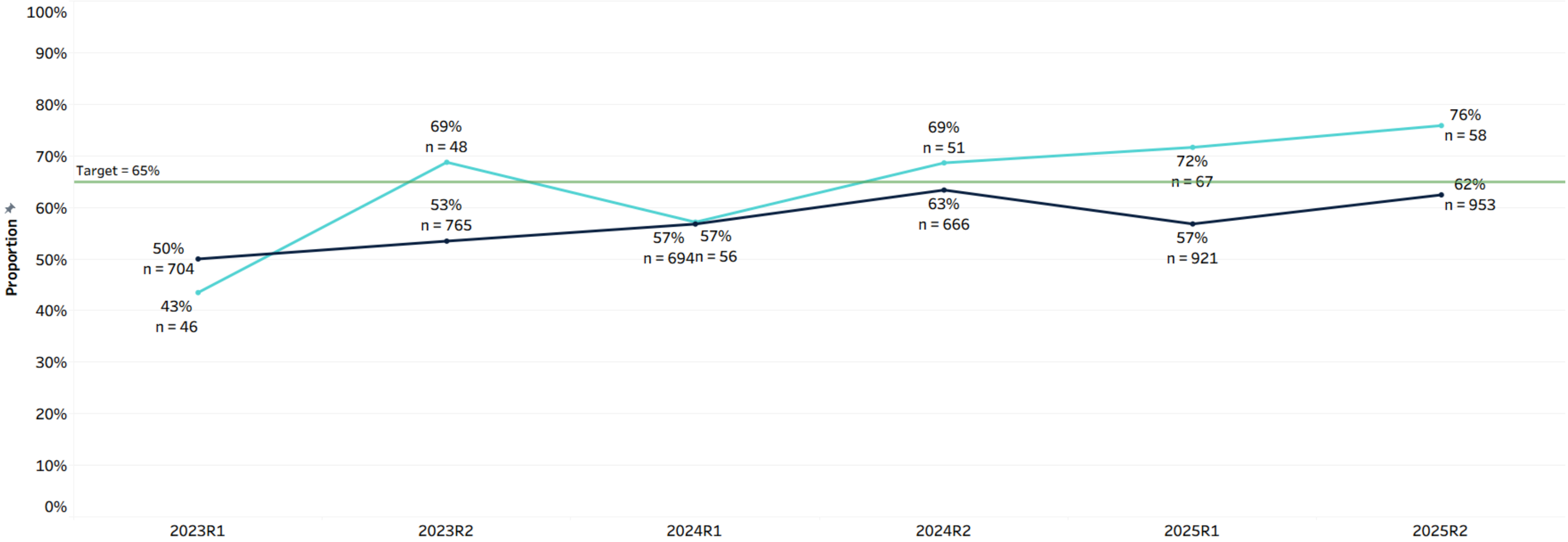
Patients receiving treatment on antiemetic clinical trial excluded.

Target updated in 2026. Previous Target: 60%

MEQC Measure

VBR Measure

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



Target updated in 2026. Previous Target: 60%

Color Legend

- MOQC - All
- MOQC - GYN

Trend slides use rounds to highlight trends over time – each round represents 6 months of calendar year data

OLANZAPINE

WHY AM I GETTING A PRESCRIPTION FOR OLANZAPINE?

The cancer treatment that you will be getting can cause nausea or vomiting. We do everything we can to reduce this side effect. Olanzapine is highly effective, even in small doses, at decreasing nausea and vomiting and is an important part of your care.

WHAT SHOULD I EXPECT WHEN I GO TO THE PHARMACY?

Olanzapine was originally approved for people with certain mental illness. The pharmacist may tell you about the original reason the drug was used when you drop off your prescription or pick up your medication. We want you to be prepared for this possibility. You may wish to tell the pharmacist why you have been prescribed olanzapine and that your cancer team is prescribing olanzapine for a completely different reason. This original approval for the medication does not make your insurance or your medical record think you have the certain mental illness when you get the prescription.

WHAT ABOUT THE SIDE EFFECTS?

Nearly all the side effects listed for this medication occur in people who are on higher doses of the medicine and who take the medicine every day for many years. People who take olanzapine for chemotherapy are not likely to get side effects other than tiredness. It is often recommended that you take it in the evening because of this.

IS OLANZAPINE COVERED BY INSURANCE? IS IT EXPENSIVE?

This medication is much less expensive than other medicines used to prevent side effects of chemotherapy. The cost for each pill is about 20 cents. Most insurance will cover the cost, but you can also choose to pay for it on your own if insurance does not cover it.

THESE SITES MAY BE HELPFUL TO LEARN MORE ABOUT NAUSEA AND VOMITING RELATED TO CANCER TREATMENT:

National Cancer Institute - www.cancer.gov
American Cancer Society - www.cancer.org
American Society of Clinical Oncology - www.cancer.net
National Comprehensive Cancer Network - www.nccn.org

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115: NK1 Receptor Antagonist & Olanzapine Given as Part of a 4-Drug Regimen with High Emetic Risk Chemotherapy

What is this measure?

- High emetic risk chemotherapy is defined as greater than 90% frequency of emesis (vomiting) from chemotherapy in the absence of effective preventative measures
- Goals of this measure include:
  - Increasing the use of guideline-concordant prescribing of antiemetic therapy
  - Increasing the use of olanzapine
  - Reduce unplanned medical care or hospitalization
- 4-Drug Antiemetic Regimen For High Emetic Risk Chemotherapy:
  - Neurokinin-1 Receptor Antagonists (NK1RA)
  - 5HT3 Receptor Antagonists
  - Corticosteroids
  - Olanzapine
- Resources:
  - ASCO Guidelines: https://ascopubs.org/doi/10.1200/JCO.20.01296
  - NCCN Guidelines: https://pubmed.ncbi.nlm.nih.gov/28687576/

Why is this measure important?

- Chemotherapy-induced nausea and vomiting (CINV) is a feared side effects of cancer treatment
- If not adequately controlled, CINV can add to patients' morbidity, cost of therapy, and impair the patient's quality of life
- Appropriate use of antiemetics in patients receiving high emetic risk chemotherapy improves symptoms, decreases unscheduled medical care, and reduces the risk of unplanned hospitalization

What is included in this measure?

- Determine if patient received chemotherapy
  - Chemotherapy administered, date of chemotherapy start, patient received IV chemotherapy during cycle 1 of initial chemotherapy treatment (yes/no), start date of IV chemotherapy during cycle 1 of initial treatment
- Determine emetic risk of chemotherapy received
- Determine what antiemetics were administered including dates of administration

Where can abstractors find this information?

- Medication Administration Record (MAR)
- Chemotherapy Flowsheet
- Medication List or Pharmacy Records
- Abstractors may use the search option in some EMRs

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QUESTIONS?
https://moqc.org/
moqc@moqc.org

Gyn Onc Surgery Measures

- Days from surgery to chemotherapy start in ovarian, peritoneal, and fallopian tube cancers
- Prescribing of opioids after hysterectomy (any modality)

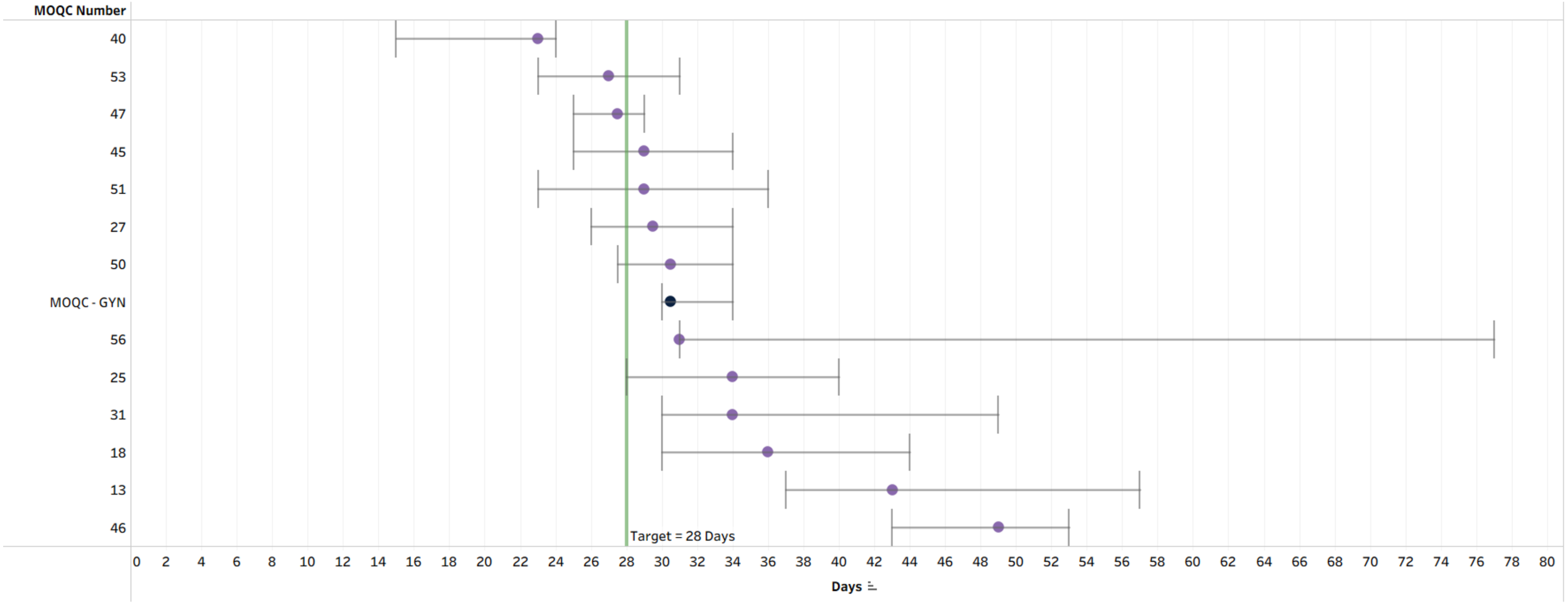
MEQC Measure

VBR Measure

123: Days from Surgery to Chemotherapy Start in Ovarian, Peritoneal, and Fallopian Tube Cancers

(Lower Score = Better)

2/1/2025 - 1/31/2026, n = 220



MEQC Measure

VBR Measure

123: Days from Surgery to Chemotherapy Start in Ovarian, Peritoneal, and Fallopian Tube Cancers

(Lower Score = Better)

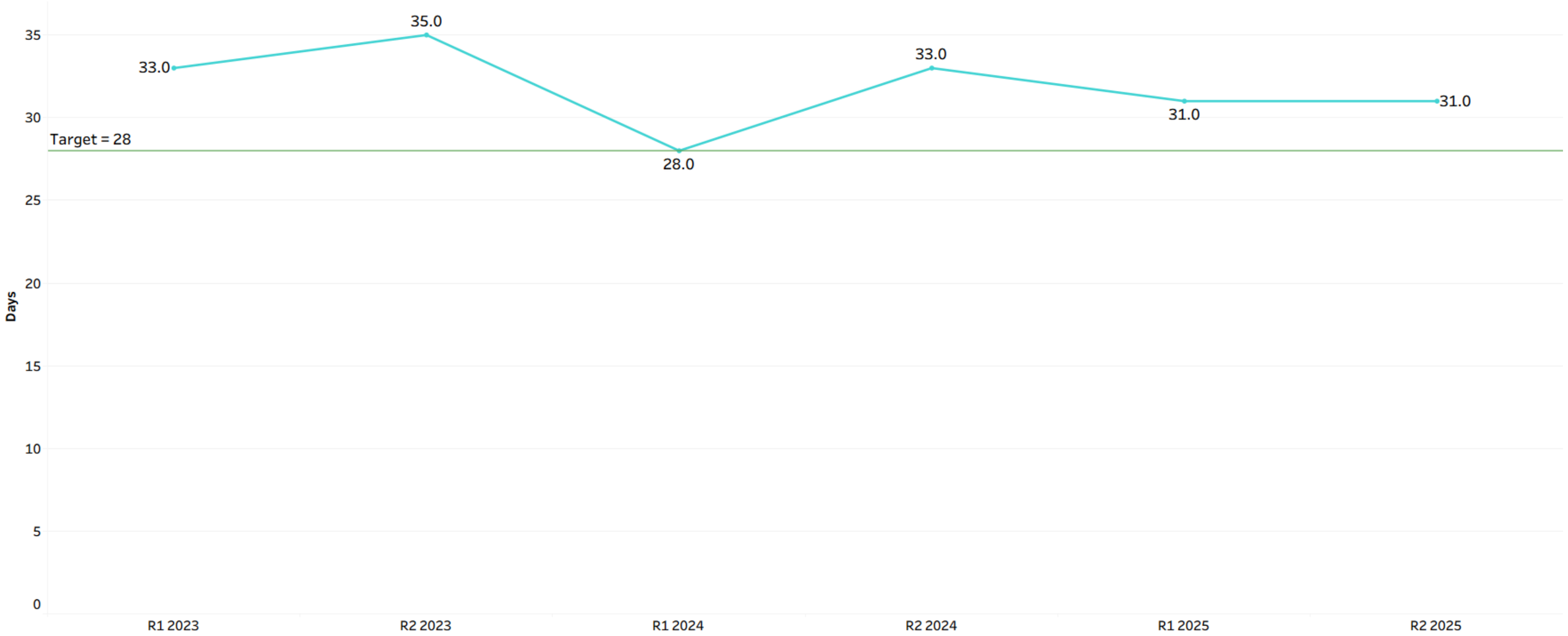
2/1/2025 - 1/31/2026, n = 220

MOQC Number	Chart Count	Median Days
40	13	23.0
53	15	27.0
47	40	27.5
45	23	29.0
51	7	29.0
27	16	29.5
50	20	30.5
56	3	31.0
25	25	34.0
31	11	34.0
18	8	36.0
13	25	43.0
46	14	49.0
Total	**220**	**30.5**

MEQC Measure

VBR Measure

123: Days from Surgery to Chemotherapy Start in Ovarian, Peritoneal, and Fallopian Tube Cancers
(Lower Score = Better)



Trend slides use rounds to highlight trends over time – each round represents 6 months of calendar year data

Publication QR

Clinical Trial > Ann Oncol. 2016 Jan;27(1):114-21. doi: 10.1093/annonc/mdv500.
Epub 2015 Oct 20.

Early initiation of chemotherapy following complete resection of advanced ovarian cancer associated with improved survival: NRG Oncology/Gynecologic Oncology Group study

K S Tewari [1], J J Java [2], R N Eskander [3], B J Monk [4], R A Burger [5]

Affiliations + expand

PMID: 26487588 PMCID: PMC4684156 DOI: 10.1093/annonc/mdv500

Abstract

Background: To determine whether time from surgery to initiation of chemotherapy impacts survival in advanced ovarian carcinoma.

Patients and methods: This is a post-trial ad hoc analysis of Gynecologic Oncology Group protocol 218, a phase III randomized, double-blind, placebo-controlled trial designed to study the antiangiogenesis agent, bevacizumab, in primary and maintenance therapy for patients with newly diagnosed advanced ovarian carcinoma. Maximum attempt at debulking was an eligibility criterion. Stage III patients, not stage IV, were required to have gross macroscopic or palpable residual disease following surgery. The survival impact of time from surgery to initiation of chemotherapy was studied using Cox regression models and stratified by treatment arm, residual disease and other clinical and pathologic factors.

Publication QR

ELSEVIER

Gynecologic Oncology
Volume 144, Issue 2, February 2017, Pages 260-265

Chemotherapy delay after primary debulking surgery for ovarian cancer

Brandon-Luke L. Seagle, Sharlay K. Butler, Anna E. Strohl, Wilberto Nieves-Neira, Shohreh Shahabi

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https://doi.org/10.1016/j.ygyno.2016.11.022 Get rights and content

Highlights

- Nearly 60% of women experience chemotherapy delay >28 days.
- Chemotherapy delay >35 days is associated with a 7% increased hazard of death.
- The evidence-based best surgery to chemotherapy interval is 21–35 days.

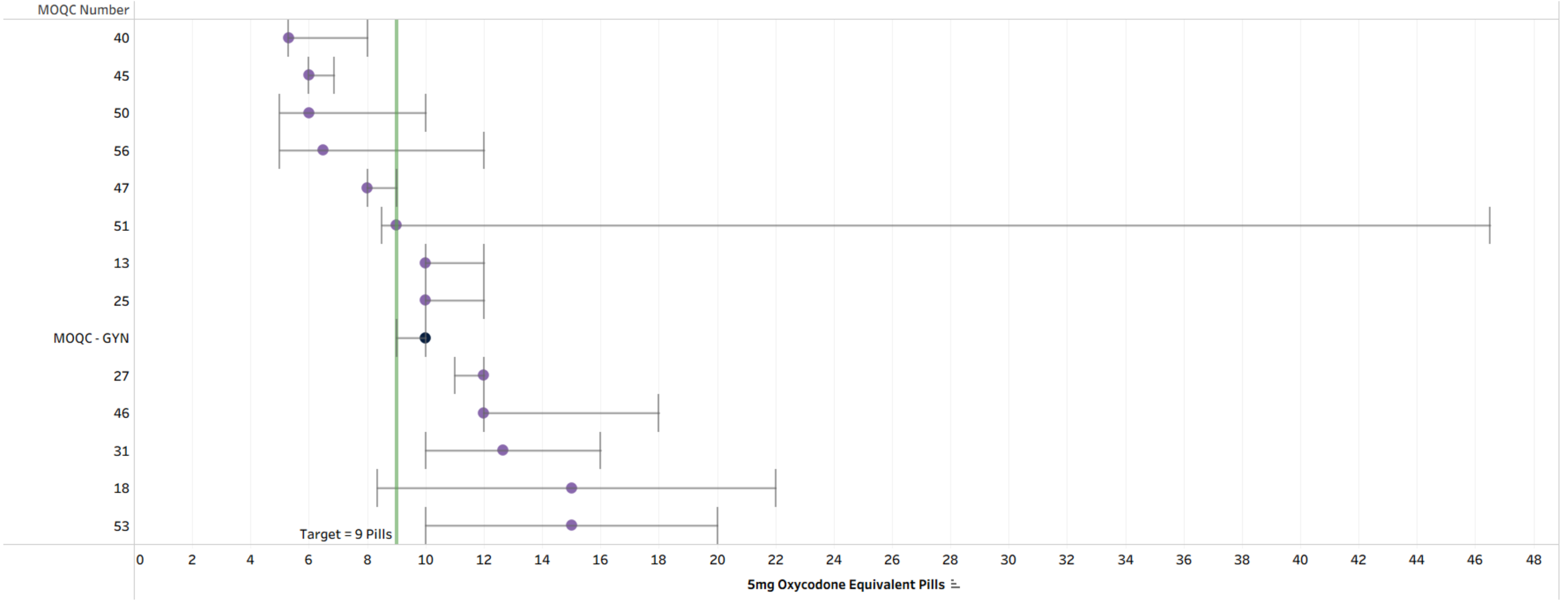
MEQC Measure

VBR Measure

116: Prescribing of Opioids for Patients After Hysterectomy (Any Modality)

(Lower Score = Better)

2/1/2025 - 1/31/2026, n = 284



MEQC Meas

VBR Measui

116: Prescribing of Opioids for Patients After Hysterectomy (Any Modality)

(Lower Score = Better)

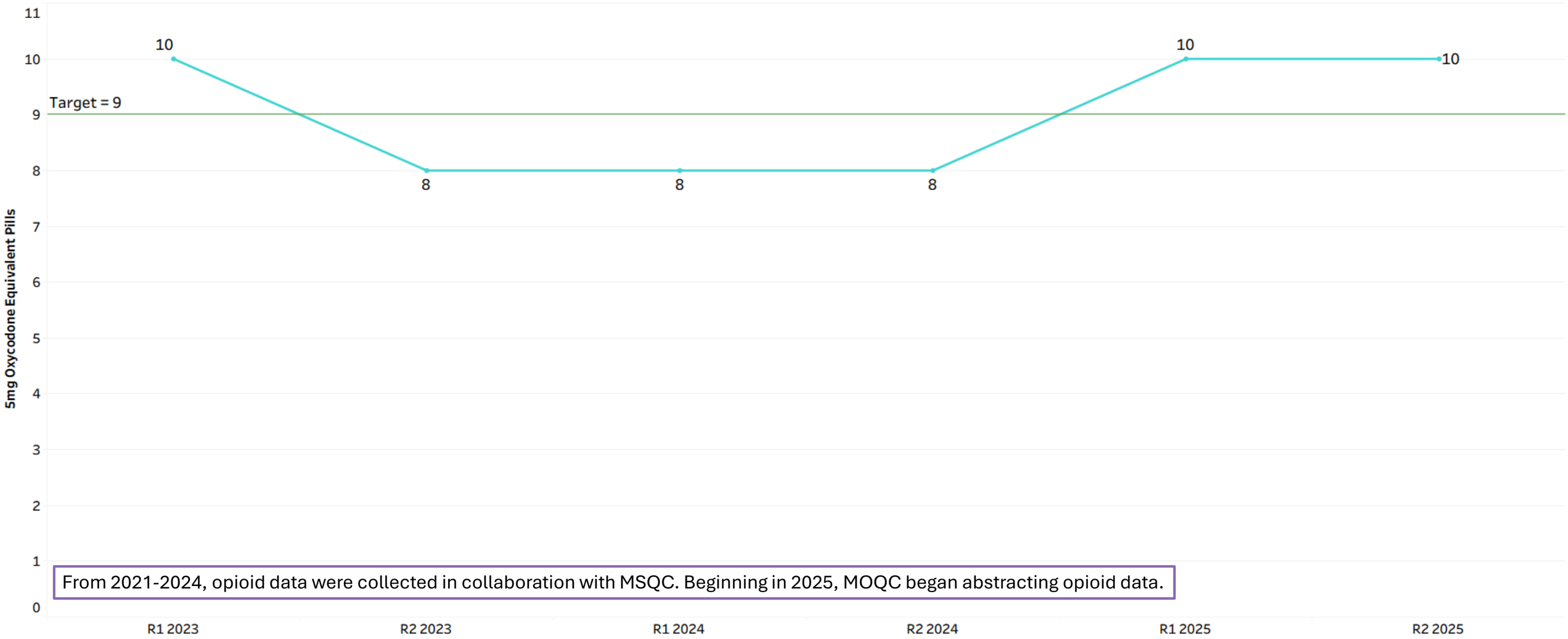
2/1/2025 - 1/31/2026, n = 284

MOQC Number	Count of Charts	Median 5mg Oxycodone Equivalent Pills
13	52	10.0
18	6	15.0
25	29	10.0
27	18	12.0
31	14	12.7
40	15	5.3
45	34	6.0
46	21	12.0
47	47	8.0
50	19	6.0
51	6	9.0
53	13	15.0
56	10	6.5
Total	**284**	**10.0**

MEQC Measure

VBR Measure

116: Prescribing of Opioids for Patients After Hysterectomy (Any Modality)
(Lower Score = Better)



From 2021-2024, opioid data were collected in collaboration with MSQC. Beginning in 2025, MOQC began abstracting opioid data.

Trend slides use rounds to highlight trends over time – each round represents 6 months of calendar year data

MOQC Opioid Calculator

www.opioidcalculator.org

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About | Abstraction | Patients/Caregivers | Initiatives | News & Events | Resources

Opioid Calculator

MOQC Opioid Calculator

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I agree that the website host and developer will not be held responsible for any errors or consequences in management of patient care resulting from such errors. I will confirm that the information is correct before using it in any documentation.

Age	≤20 | 20-39 | 40-59 | 60-79 | ≥80
History of Depression	No | Yes

Publication QR

Gynecol Oncol. 2021 Sep;162(3):756-762. doi: 10.1016/j.ygyno.2021.06.023. Epub 2021 Jul 3.

Optimization of postoperative opioid prescriptions in gynecologic oncology: Striking a balance between opioid reduction and pain control

Alli M Straubhar [1], Liam Dalton [2], Aimee Rolston [2], Kevin McCool [2], Olivia De Bear [2], Cynthia Stroup [2], R Kevin Reynolds [2], Karen McLean [2], Jean H Siedel [2], Shitanshu Uppal [2]

Affiliations + expand

PMID: 34226021 DOI: 10.1016/j.ygyno.2021.06.023

Abstract

Objective: To implement a quality-improvement initiative to assess the impact various patient and procedural factors have on postoperative opioid use. To develop a tailored opioid prescribing algorithm for gynecologic oncology patients.

Methods: A retrospective cohort study was performed of patients who underwent a laparoscopy or laparotomy procedure for a suspected or known gynecologic malignancy between 3/2019-9/2020. Patients were assessed preoperatively for the presence of suspected risk factors for opioid misuse (depression, anxiety, chronic pain, current opioid use, or substance abuse). Patients completed a 30-day postoperative questionnaire assessing for total opioid pill use and refills requests. Multivariate

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DISCUSSION

End-of-Life Measures

- Hospice enrollment
- Median time on hospice
- Palliative care consultation
- Anticancer therapy administration

CHART SELECTION CRITERIA

Chart Selection Criteria for Presented Data

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Abstracted February 1, 2025 – January 31, 2026

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

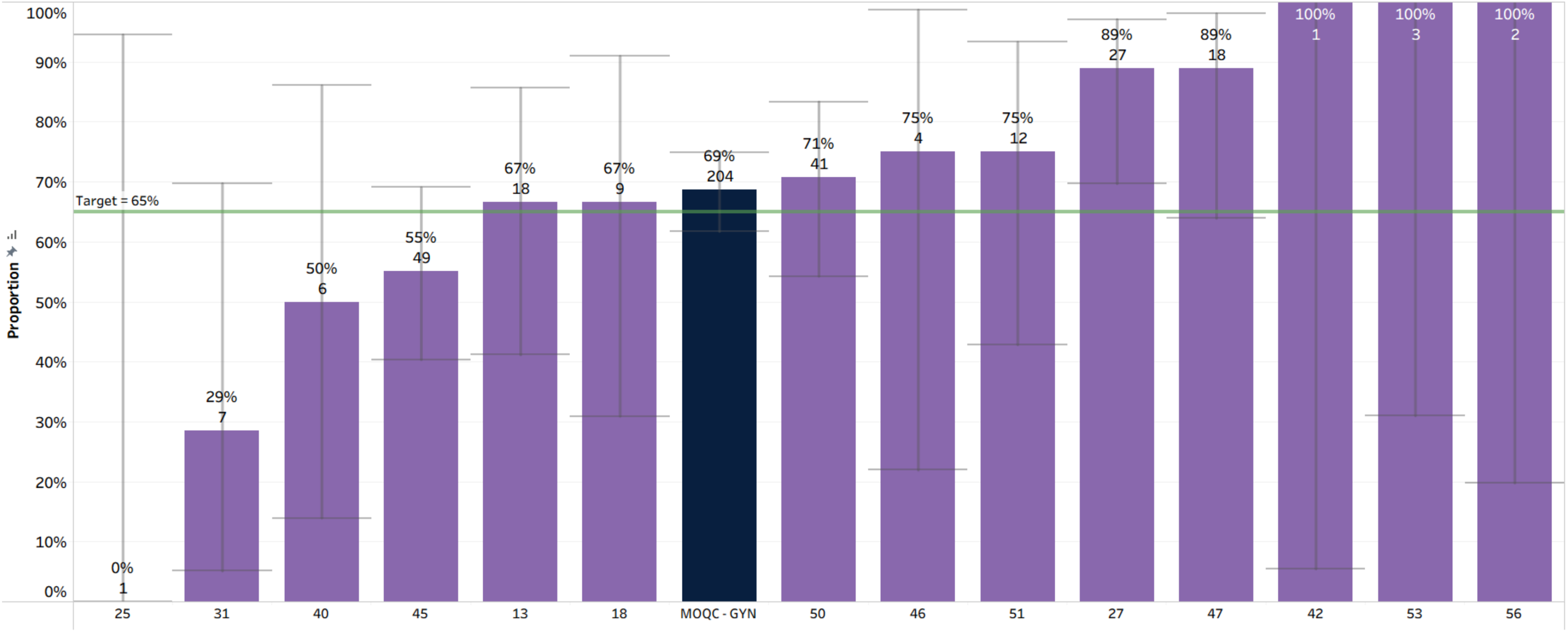
EOL patients only need to meet criteria below:
Patient must have died 12/1/2023 – 5/31/2026
Patient must have a known date of death
Death related to cancer or cancer-related treatment
2 office visits (practitioner): Within 12 months preceding death

*Hematologic malignancies excluded from measures 126a, 126b, 126c, 127, 127a, 128

MEQC Measure

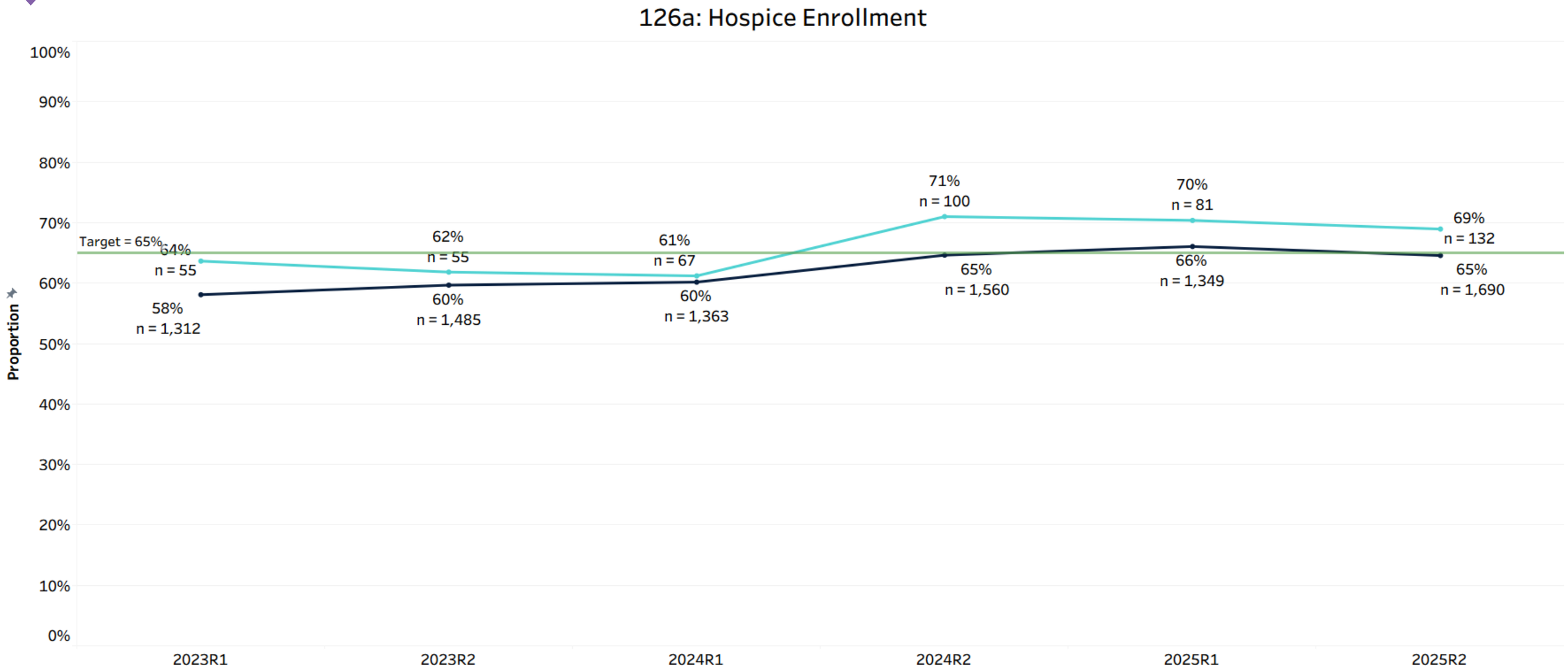
VBR Measure

126a: Hospice Enrollment
2/1/2025 - 1/31/2026, n = 204



MEQC Measure

VBR Measure

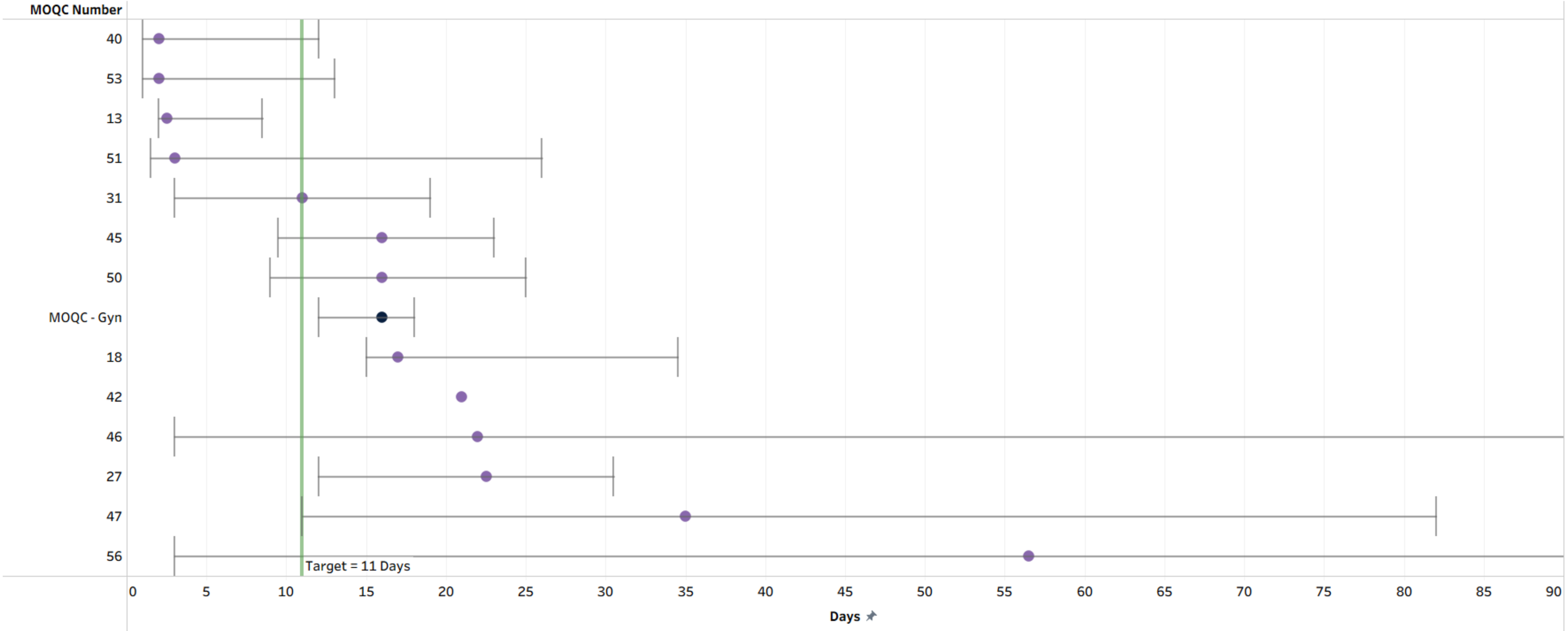


Trend slides use rounds to highlight trends over time – each round represents 6 months of calendar year data

MEQC Measure

VBR Measure

126d: Median Days on Hospice before Death
2/1/2025 - 1/31/2026, n = 135



MEQC Measure

VBR Measure

126d: Median Days on Hospice before Death
2/1/2025 - 1/31/2026, n = 135

MOQC Number	Patient Count	Median Days on Hospice
40	3	2.0
53	3	2.0
13	12	2.5
51	6	3.0
31	2	11.0
45	26	16.0
50	28	16.0
18	6	17.0
42	1	21.0
46	3	22.0
27	24	22.5
47	16	35.0
56	2	56.5
Total	**133**	**16.0**

Letter Templates

- Hospice Patient Enrollment Notification Template
- Hospice Patient Death Notification Template

MOQC Pathways

- Palliative Radiation for Oncology Patients with Bone Metastases
- View Map of Participating Hospices & Radiation Oncology Practices
- Palliative Radiation for Oncology Patients on Hospice with Bleeding

WHAT MATTERS TO YOU?

Deciding if Hospice is Right for You

CONVERSATION GUIDE

WHAT WILL I DO WHEN MY LOVED ONE IS ON HOSPICE?

Caring for a loved one with a serious illness is one of the most important roles you can play. As the primary caregiver while your loved one is on hospice, your tasks range from buying groceries and cooking meals, to arranging medical appointments, to providing hands-on care such as bathing and changing bed linens.

WHAT DOES HOSPICE PROVIDE FOR MY LOVED ONE AND OUR FAMILY?

- Medications that are needed for comfort
- Medical equipment and supplies
- Short-term inpatient care at approved facilities for symptoms that cannot be controlled at home
- Temporary care away from home, also called respite care.
- Other complimentary services such as volunteers, music therapy, massage, and pet therapy may be available.

YOUR WELL-BEING IS IMPORTANT.

It is natural to feel isolated and burdened by the responsibilities of caregiving. You may feel unsure about the decision-making that comes with being a caregiver. You may feel doubts about your ability to care for your loved one.

HOW CAN HOSPICE HELP?

Hospice professionals can show you how to do many of these important tasks. You will have a team, including a nurse, doctor, social worker, home health aides, and spiritual care, that will help you with the physical responsibilities of caregiving and support your emotional needs. You may reach out to your hospice team whenever you need them.

Hospice can also help you develop a plan to meet your own needs and find other resources. Reaching out to family, friends, your church, or your social groups can also be especially helpful.

WHAT ELSE SHOULD I KNOW?

Enrolling your loved one in hospice is optional. Hospice care can be cancelled or changed for any reason at any time.

Talk about hospice with your family and friends. Sharing this pamphlet might help you to start the conversation. You can request a hospice informational visit that may help you to make a choice between hospices.

Ask about hospices in your area.

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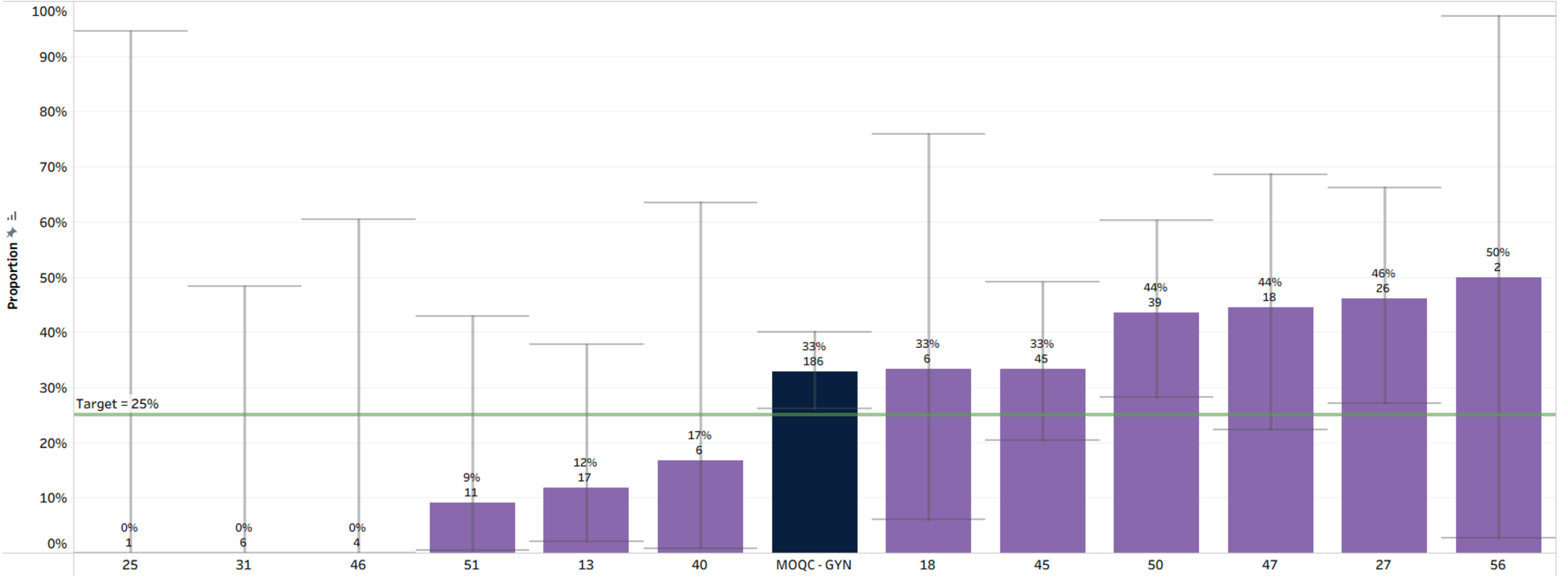
Is HOSPICE Right for MY LOVED ONE and Me?

MEQC Measure

VBR Measure

129: Palliative Care Consultation More than 90 Days Before Death
2/1/2025 - 1/31/2026, n = 186

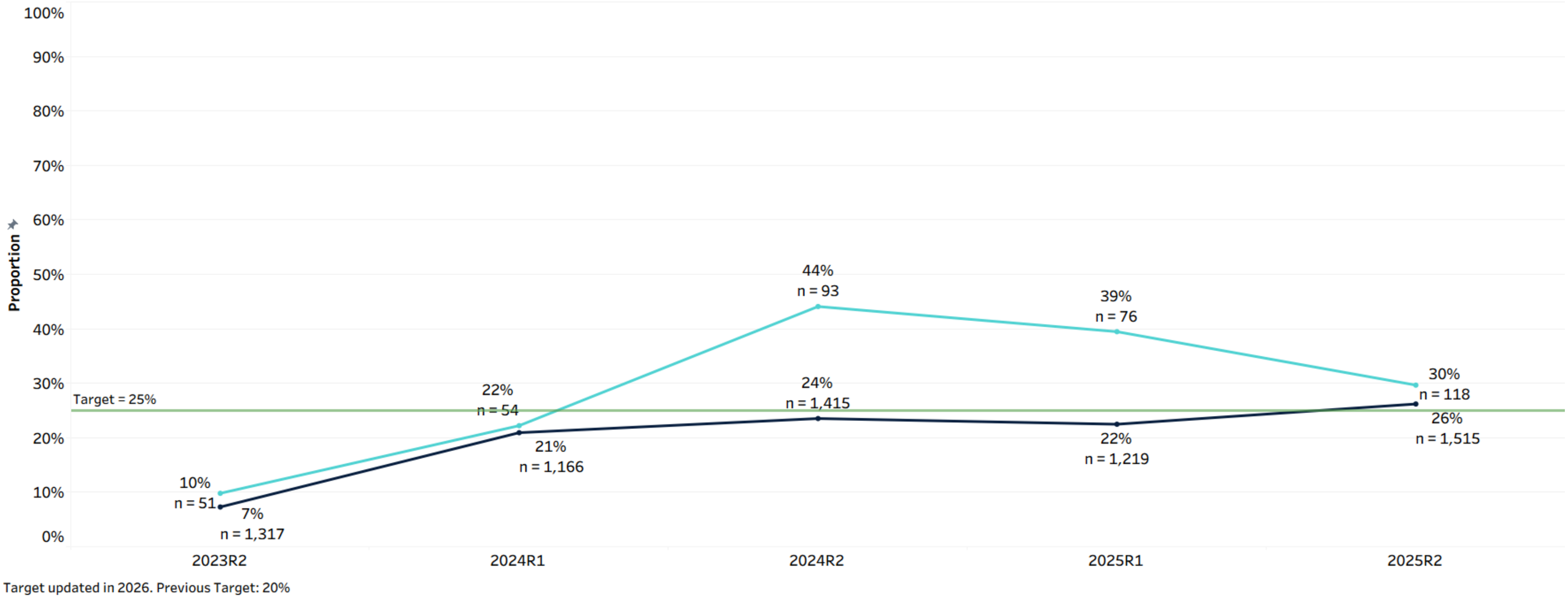


Target updated in 2026. Previous Target: 20%

MEQC Measure

VBR Measure

129: Palliative Care Consultation More than 90 Days Before Death



Target updated in 2026. Previous Target: 20%

Color Legend

- MOQC - All
- MOQC - GYN

Trend slides use rounds to highlight trends over time – each round represents 6 months of calendar year data

Looking for Relief While Going Through Cancer?

Palliative care can help at any stage of your journey.

What is Palliative Care?

Palliative care is specialized care that focuses on relieving pain and symptoms of serious illness while helping you cope with side effects of treatment.

Is Palliative and Hospice Care the Same?

Often confused with hospice, palliative care can help you in any stage of treatment to help you feel better and improve your well-being.

Whether you're newly diagnosed, in treatment, or finished with treatment, palliative care can support you.

What is the Difference Between Palliative Care and Hospice?

	Palliative Care	Hospice
Goal	Focuses on managing pain and symptoms from cancer and treatment to improve overall well-being and quality of life.	Focuses on care for cancer patients near the end of life, prioritizing comfort instead of treatment to improve quality of life.
When	Available at any point during your cancer care, even right after diagnosis. There are no time limits.	Provides comfort as cancer treatment ends and the focus shifts to end-of-life care.
Where	Offered at local clinics, hospitals, cancer centers, or at your home.	Offered at hospice centers, retirement communities, hospitals, or at your home.
Team	Oncologists, nurses, social workers, pharmacists, physical therapists, and interfaith chaplains work together relieving symptoms and stress of your illness.	Hospice physicians, nurses, social workers, pharmacists, home aides, and interfaith chaplains provide end-of-life care and support.

How Can Palliative Care Improve My Life?

Palliative care helps support your physical, emotional, social, and spiritual needs.

Physical Needs

- Pain from cancer
- Nausea or vomiting
- Loss of appetite

Emotional Needs

- Anxiety about cancer
- Depression or sadness
- Loss of control
- Fear of dying

Social Needs

- Caregiver support
- Financial support
- Food and nutrition support
- Transportation
- Housing support

Spiritual Needs

- Spiritual and faith-based support
- Connection to support groups
- Creating connection with loved ones

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Palliative Care Certificate Program: Cohort 2

The CAPC MOQC Palliative Care Certificate Program equips participants with practical primary palliative care skills to deliver compassionate, person-centered care, whether you are just getting started or looking to strengthen your approach.

Application open Jan 6-23, 2026 to

- Oncology APPs (NPs and PAs) from MOQC practices
- Primary care and oncology Physicians, NPs, and PAs from FQHCs and tribal clinics

Center to Advance Palliative Care™ capc

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PROGRAM HIGHLIGHTS:

- Access to all CAPC resources during training
- Tuition covered by MOQC ($2,500 per person)
- Highly experienced instructors
- 8-10 hours monthly time commitment
- Continuing education credits
  - 28.75 CME/33.55 Nursing Contact Hours
- Building a Michigan network of palliative care providers
- Graduation celebration

IMPORTANT 2026 DATES:

Kick off/Orientation Event (5.30-7pm EST):

March 19

Virtual Clinical Discussions (6-7pm EST):

April 23 ● May 21 ● June 25 ● Aug 27 ● Sept 24

Capstone Presentation (1-4pm EST): Oct 22

2026 Virtual Training Schedule

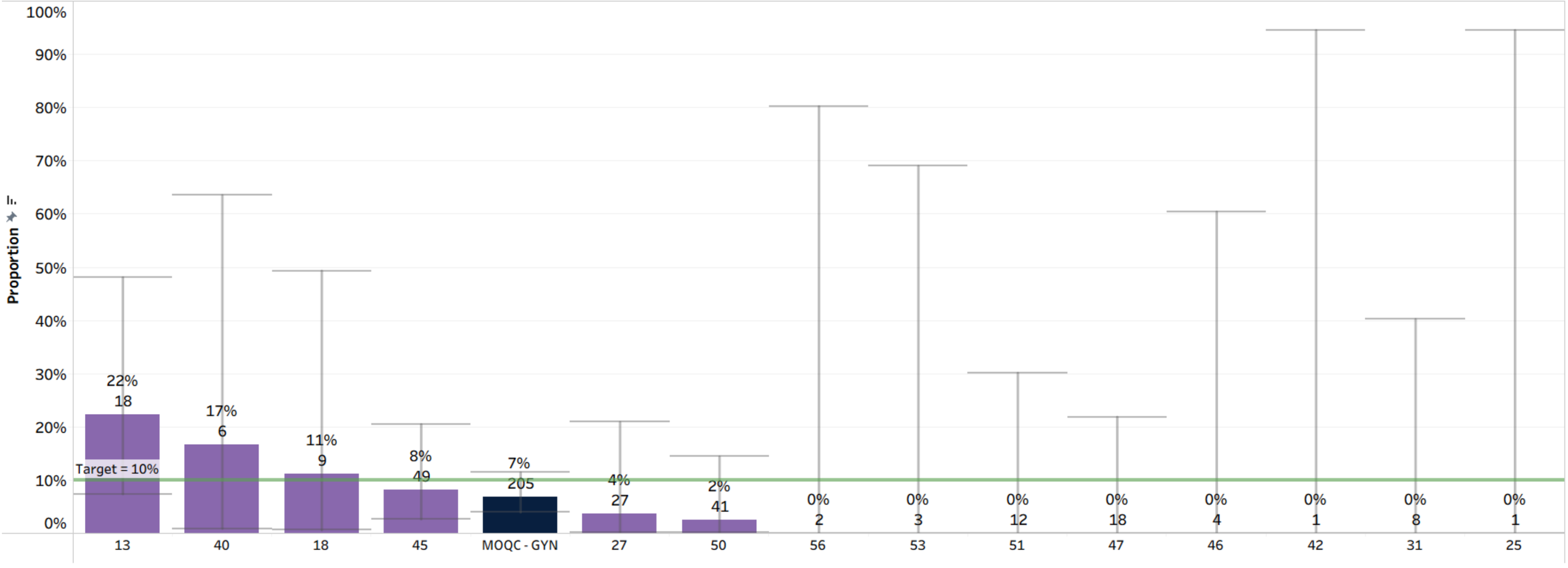
April	Assessing the needs of patients and caregivers
May	Strengthening the patient-clinician relationship and understanding care goals
June	Non-pain symptom management
July	Break in training
August	Pain management
Sept	Preventing crises and planning ahead
Oct	Capstone project

Application deadline January 23, 2026

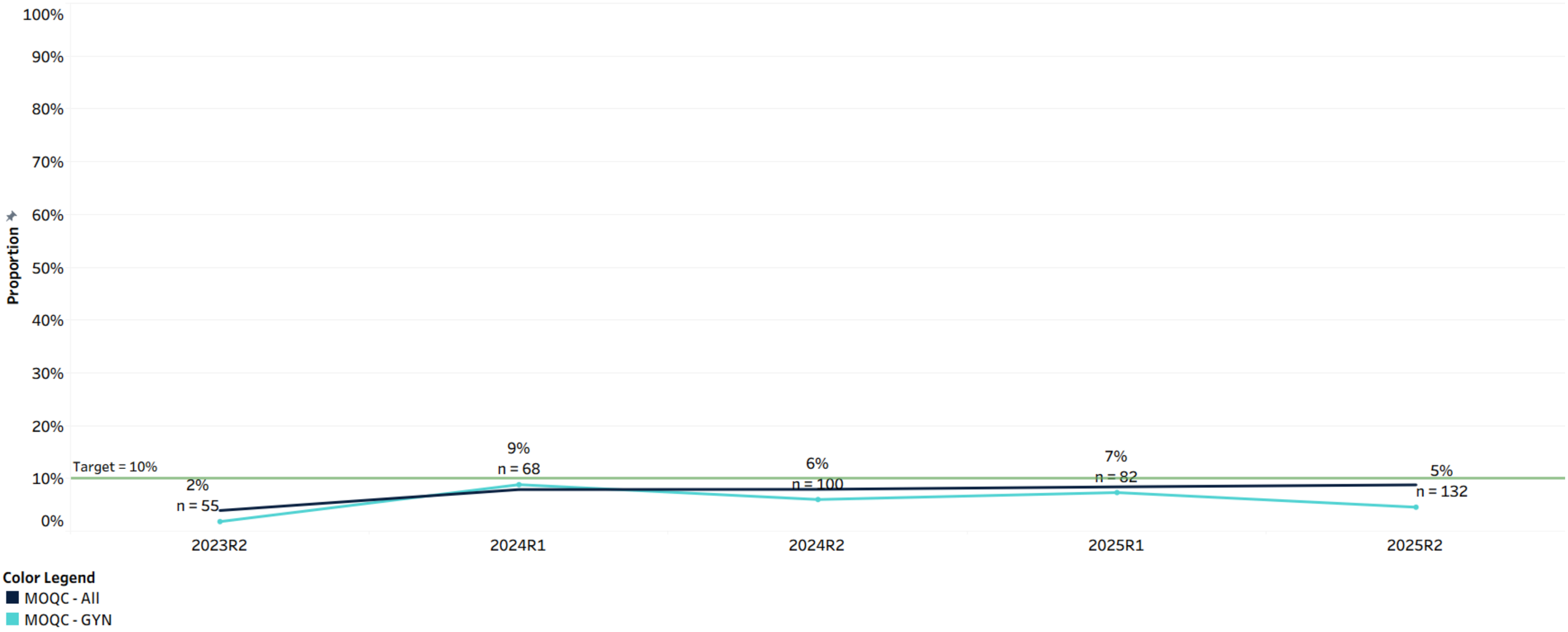
Applications available January 6 at the link or QR code https://moqc.org/initiatives/clinical/moqc-capc-palliative-care-certificate-program/

Questions? moqc@moqc.org

127a: Any Anticancer Therapy, Including Chemotherapy, Administered within the Last 14 Days of Life
(Lower Score = Better)
2/1/2025 - 1/31/2026, n = 205

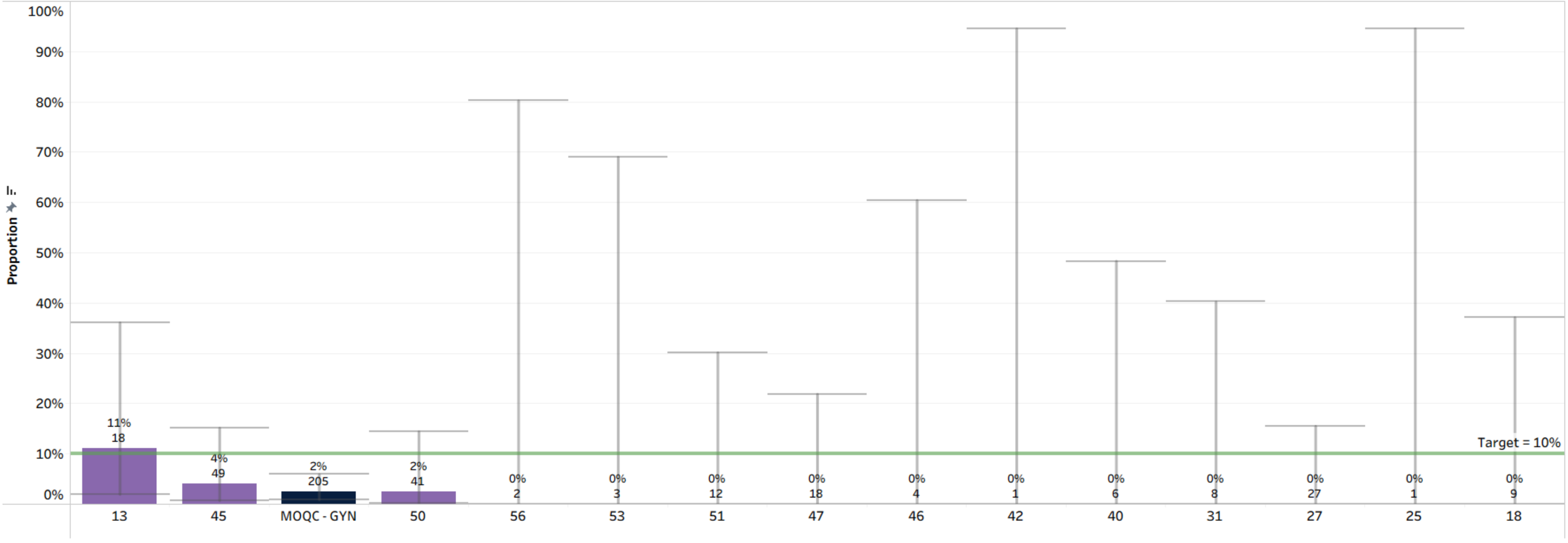


127a: Any Anticancer Therapy, Including Chemotherapy, Administered within the Last 14 Days of Life (Lower Score = Better)



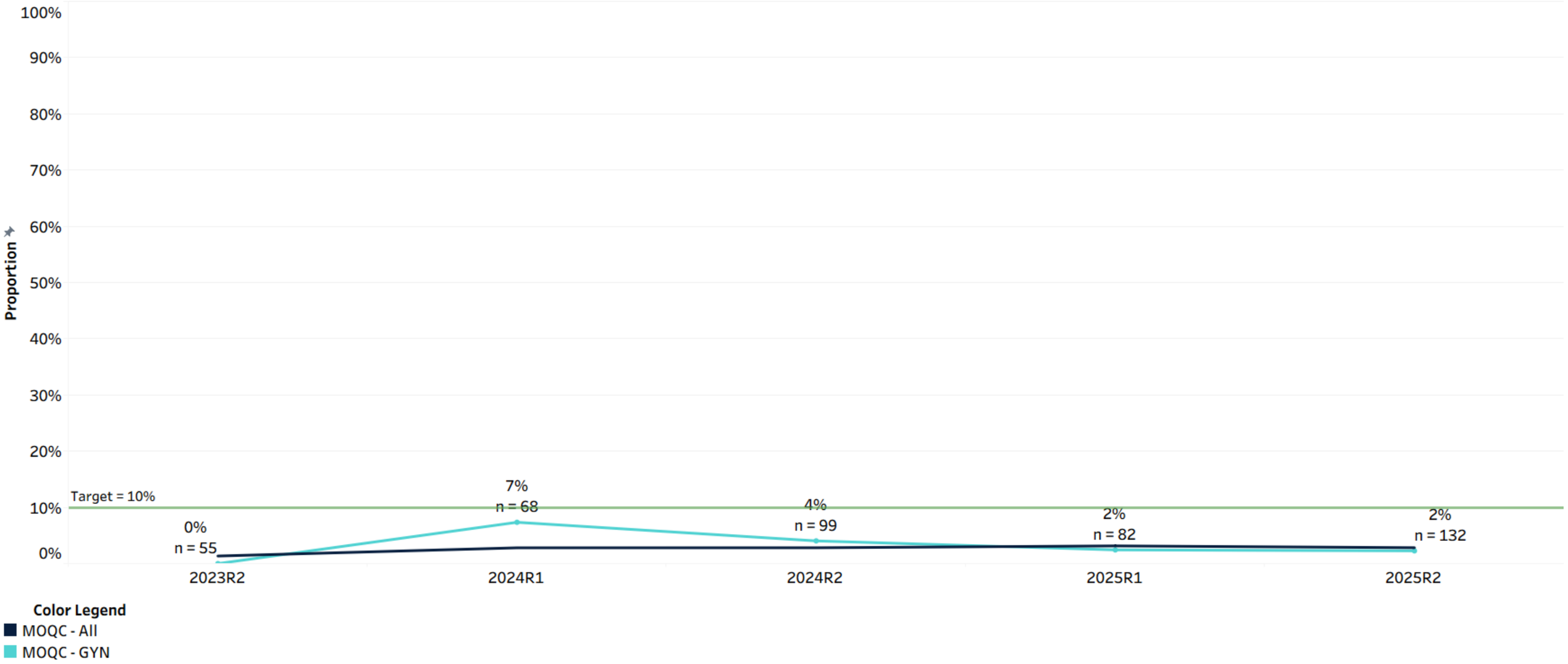
Trend slides use rounds to highlight trends over time – each round represents 6 months of calendar year data

130: Beginning a New Anticancer Regimen within the Last 14 Days of Life
(Lower Score = Better)
2/1/2025 - 1/31/2026, n = 205



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

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



Trend slides use rounds to highlight trends over time – each round represents 6 months of calendar year data

The NEW ENGLAND JOURNAL of MEDICINE

SOUNDING BOARD

Bending the Cost Curve in Cancer Care

Thomas J. Smith, M.D., and Bruce E. Hillner, M.D.

Annual direct costs for cancer care are projected to rise — from $104 billion in 2006[1] to over $173 billion in 2020 and beyond.[2] This increase has been driven by a dramatic rise in both the cost of therapy[3] and the extent of care.[4] In the United States, the sales of anticancer drugs are now second only to those of drugs for heart disease, and 70% of these sales come from products introduced in the past 10 years. Most new molecules are priced at $5,000 per month or more,[5] and in many cases the cost-effectiveness ratios far exceed commonly accepted thresholds.[6] This trend is not sustainable.[7,8]

We must find ways to reduce the costs of everyday care to allow more people and advances to be covered without bankrupting the health care system. Brody recently challenged each medical specialty to identify at least the top five tests or treatments for which costs could be substantially reduced without depriving any patient of meaningful benefit.[9] Medical oncologists directly or no benefit to surveillance testing with serum tumor markers or imaging for most cancers, including those of the pancreas, ovary,[12] or lung,[13] yet these tests are commonly used in many settings. In breast cancer, randomized studies showed that scheduled (not symptom-guided) imaging does not detect curable recurrences or alter survival. Twenty years ago, the estimated cost of wasted medical resources in the United States for patients with breast cancer was $1 billion per year.[14] The common exception is colon cancer, for which some patients do benefit from scheduled carcinoembryonic antigen testing and computed tomography.[15]

Changing practice will not be easy. Patients want reassurance that things will be "caught early," and it can be troubling to both patients and doctors to confront the realization that detecting liver metastasis when the lesion measures 1 cm rather than 2 cm does not alter the prognosis. Many practices earn ancillary income

N Engl J Med. 2011 May 26; 364(21): 2060–2065. doi:10.1056/NEJMsb1013826

130: Starting a New Anticancer Regimen within 14 Days of Death (Lower = Better)

Why do we want to decrease the number of people receiving a new anticancer regimen at the end of life?

- Beginning a new anticancer therapy when someone is close to death:
  - Creates confusion for the patient and loved ones about goals of care
  - Is not likely to lead to clinical benefit
  - Can cause toxicity, which is likely to outweigh any benefit, even when low
- Costs of therapy lead to financial strain for patients and their loved ones

For whom is this measure collected?

- All patients who died from cancer or cancer treatment

How is this measure constructed?

- Numerator: people who start a new anticancer drug(s) within 14 days of death
  - Exclusion: people receiving a new anticancer drug as part of a clinical trial
  - Exclusion: people receiving endocrine therapy
- Denominator: people who die from cancer or its treatment

Where can this measure be documented?

- Oncologist's note
- Hospice form
- Death certificate
- Medication Administration Record
- Infusion notes
- Pharmacist notes

What are the common challenges documenting this measure?

- Difficulty finding start date for oral anticancer therapy administration
- Challenges in finding date of death
- Difficulty determining if cause of death is related to cancer diagnosis/treatment
- Difficulty finding information in inpatient notes

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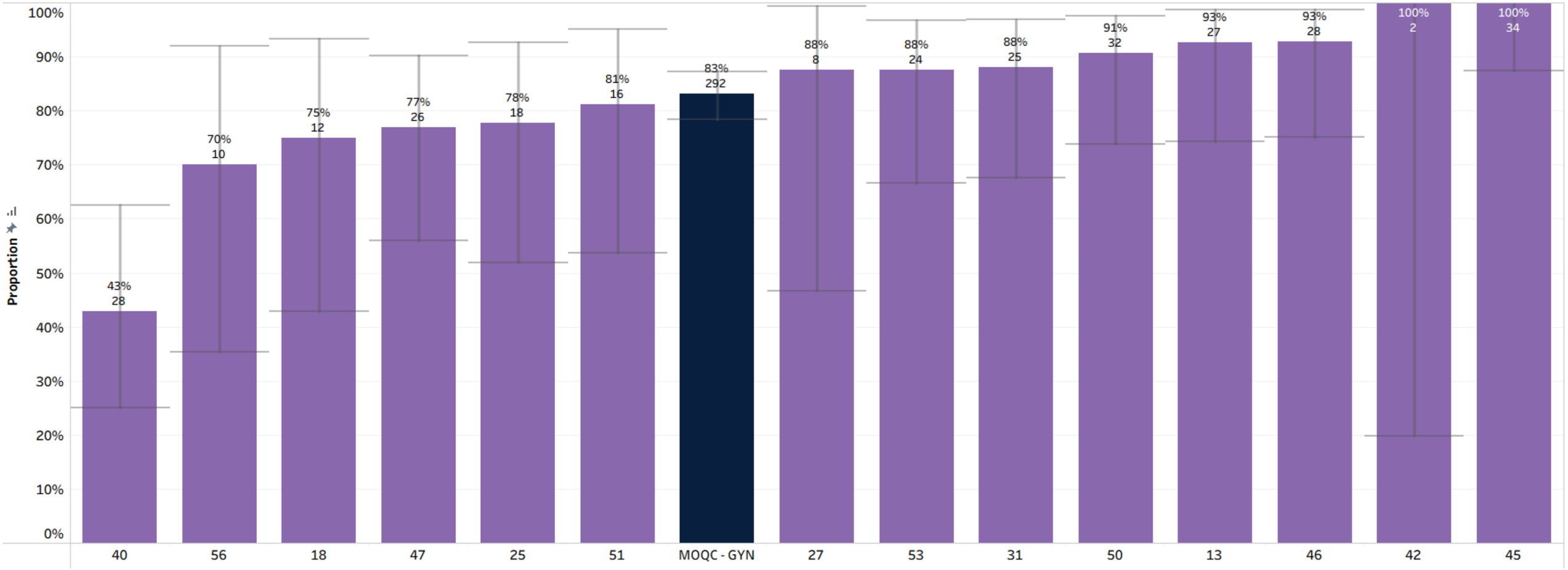
QUESTIONS?
https://moqc.org/
moqc@moqc.org

Baseline Data Collection

141: Screening for Non-Medical Needs at Least Once Per Year
8/1/2025 - 1/31/2026, n = 292



Data collection for this measure began in August 2025

MSHIELD

Non-medical Drivers of Health

The questions below will ask about non-medical needs that impact people's health, like food, housing, and transportation. Your health is very important to us at [organization/clinic]. We care about making sure our patients get the help they need.

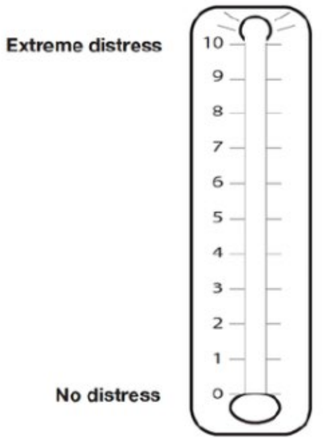
By answering these questions, we may be able to connect you to resources in your community that can help you. Many of these services are free or low-cost. We encourage you to answer these questions, even if you don't need resources. Your answers are confidential. What you share will not affect your care, insurance, or other benefits. You can skip any or all of these questions. There are no right or wrong answers.

1. Within the past 12 months, you worried whether your food would run out before you got money to buy more.
   - ❑ Often true
   - ❑ Sometimes true
   - ❑ Never true
2. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
   - ❑ Often true
   - ❑ Sometimes true
   - ❑ Never true
3. What is your living situation today?
   - ❑ I have a steady place to live
   - ❑ I have a place to live today, but I am worried about losing it in the future
   - ❑ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
4. Think about the place you live. Do you have problems with any of the following? Choose all that apply.
   - ❑ Pests such as bugs, ants, or mice
   - ❑ Mold
   - ❑ Lead paint or pipes
   - ❑ Lack of heat
   - ❑ Oven or stove not working
   - ❑ Smoke detectors missing or not working
5. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
   - ❑ Yes
   - ❑ No
6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
   - ❑ Yes
   - ❑ No
   - ❑ Already shut off
7. Do you feel physically and emotionally safe where you currently live?
   - ❑ Yes
   - ❑ No
   - ❑ Unsure
8. Would you like to receive assistance with any of these needs from [COMMUNITY HUB]?
   - ❑ Yes
   - ❑ No

NCCN Distress Thermometer for Patients

SCREENING TOOLS FOR MEASURING DISTRESS

Instructions: First please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.



Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

YES	NO	Practical Problems
❑	❑	Child care
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
❑	❑	Treatment decisions

YES	NO	Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family health issues

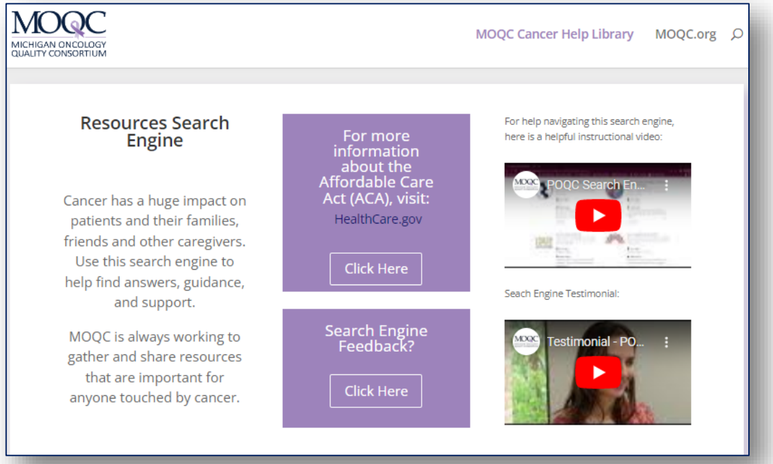
YES	NO	Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities
❑	❑	Spiritual/religious concerns

YES	NO	Physical Problems
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urination
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling Swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Substance abuse
❑	❑	Tingling in hands/feet

Other Problems: _____

2·1·1 Michigan

paf Patient Advocate Foundation



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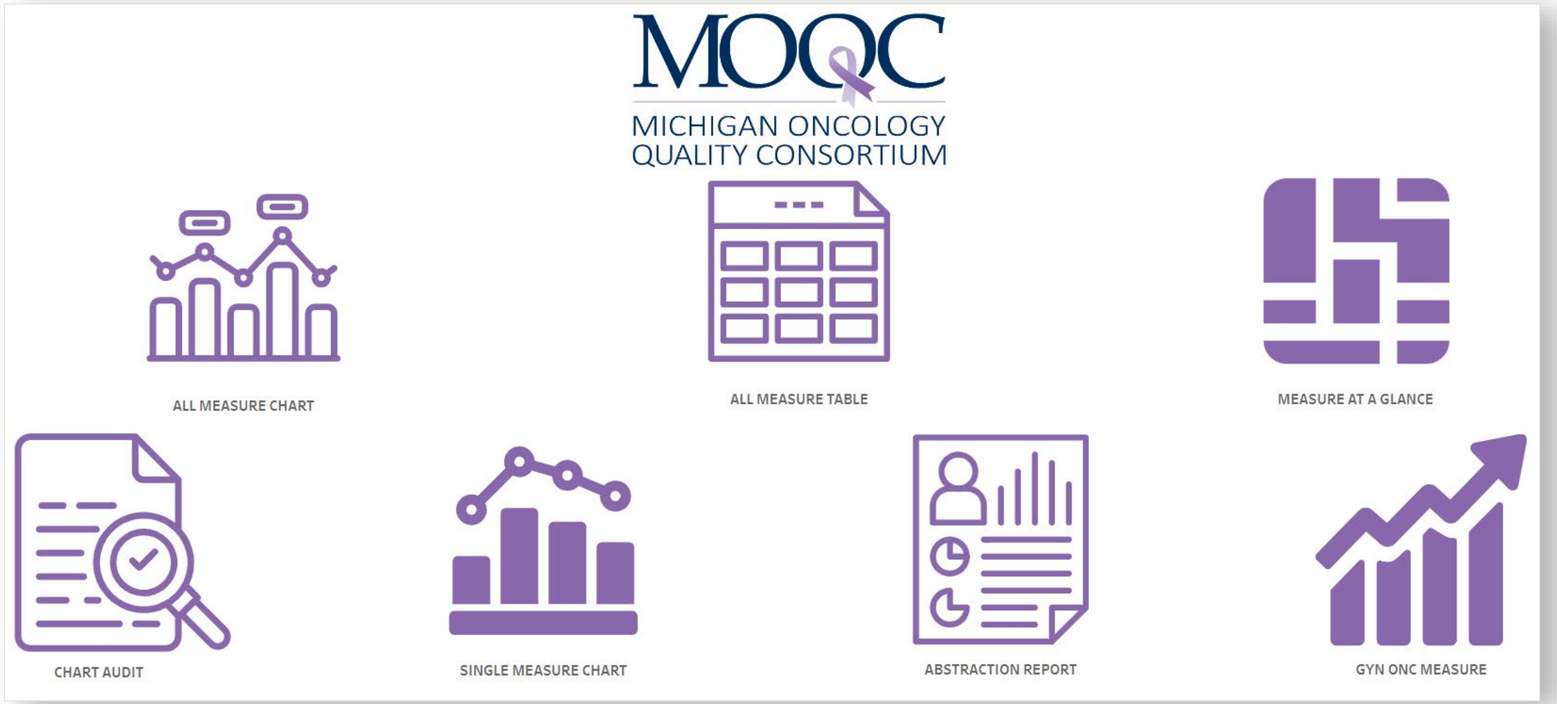
DISCUSSION

MOQC Dashboards

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



To request a dashboard account contact moqc@moqc.org

5 Minute Break

Voice of the Caregiver

Jacob Sierocki, POQC

Proficient or Deficient?Evolving Knowledge and Therapeutic Strategies in Advanced/Recurrent Endometrial Cancer

Amanda Nickles Fader, MD

Closing

Keli DeVries, LMSW

THE ANGEL FUND

Created in loving memory of Angela “Angel” Marie Geller, this new program provides direct financial assistance through a prepaid gift card to help ease unexpected expenses during treatment.

Inspired by Angel’s kindness and generosity, The Angel Fund continues her legacy of lifting up others when they need it most.

Residents of Michigan who are currently in treatment for ovarian cancer or who have been in treatment within the last six months are eligible to apply.

SUPPORT GROUPS

MIOCA helps facilitate monthly support groups to ensure individuals who have been diagnosed and family members throughout the state have access to a network of community support. These groups are hosted virtually and accessible statewide.

We currently offer Younger Survivors, Teal Sisters, and a Friends & Family Support Group.

SUPPORT TOTES

Survivor Support Totes are packages containing gifts and helpful information for women across Michigan who have received an ovarian cancer diagnosis or are experiencing a recurrence.

Scan the QR code or visit mioca.org to learn more.

info@mioca.org
734.800.6144

MIOCA
Michigan Ovarian Cancer Alliance

Caregiver Navigation
Training Opportunity

PROGRAM GOALS:

- ✓Navigator Training
- ✓Oncology Integration
- ✓Resource Coordination
- ✓Advocacy

SCHEDULED DATES:

Wednesdays, 12:00-1:00pm via Zoom

February 25 – March 25

Caregiver-specific training is for navigators or those acting as navigators within MOQC practices

IF INTERESTED, VISIT:

Or email moqc@moqc.org

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RUSH

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Interprofessional Development

UPCOMING SESSIONS:

- Advance Care Planning
- Financial Navigation

MOQC Connection Visits

Review practice performance & patient list eligibility

Celebrate your successes

Brainstorm ideas for performance improvement

Review printed and digital resources

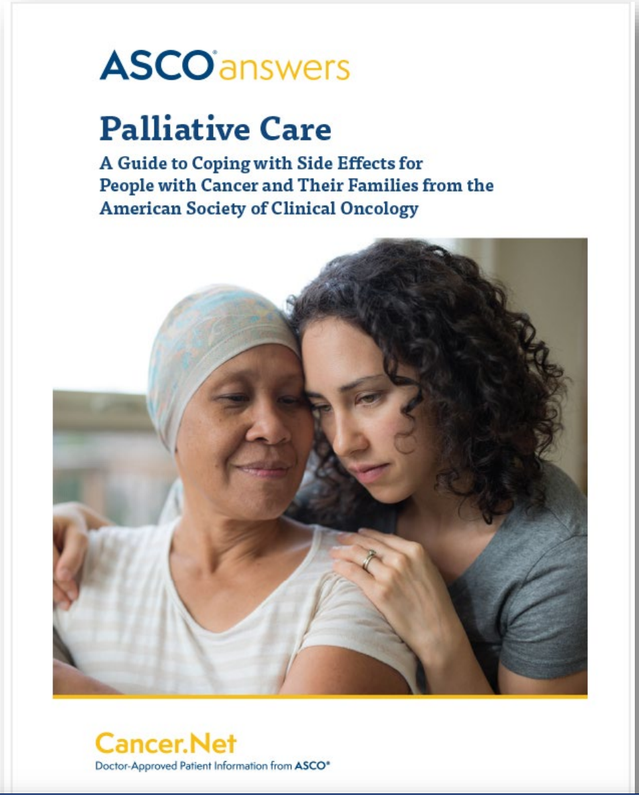
In-person and virtual options are available!

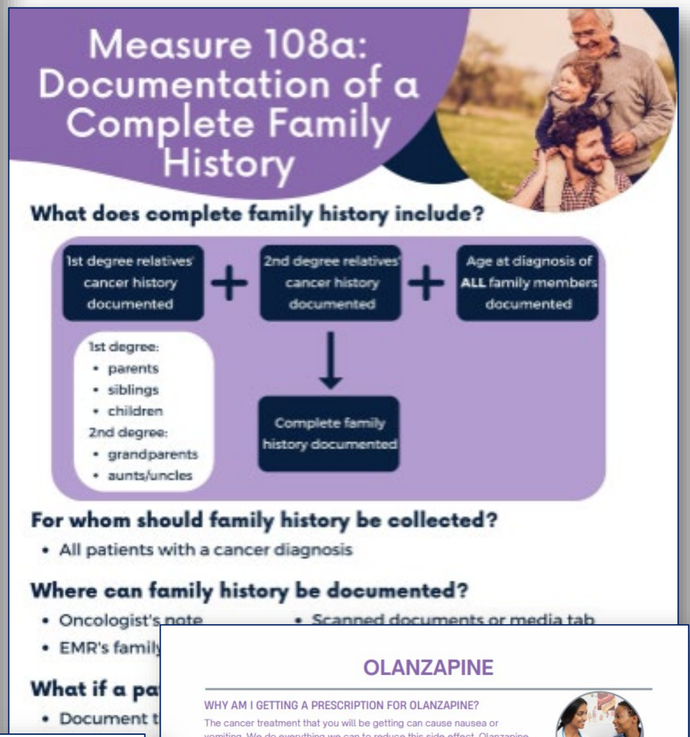
MOQC Resources

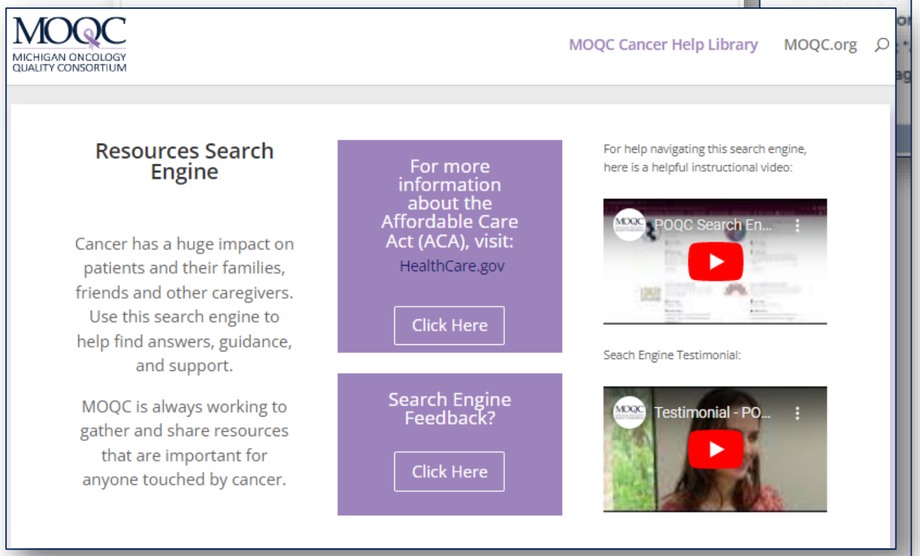
- MOQC has a variety of free resources for your **patients**, **caregivers**, and **clinicians**

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

www.moqc.org







Continuing Education Credits

MOQC
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This meeting has been approved for 3 CEU

Credit Designation
AMA PRA Category 1 Credits™ (3.00 hours), Non-Physician Attendance (3.00 hours)

Additional details about claiming CE credits:
https://moqc.org/resources/claiming-ce-credits/
Credit needs to be claimed within 7 days.

Please reach out to Vanessa Aron (vclinton@med.umich.edu) with any questions.

Your Next Meeting

Gynecologic Oncology
Fall Biannual Meeting
Friday, October 23
(Midland)

AI in Gynecologic Oncology: Pros and Cons

Other MOQC Opportunities

Medical Oncology
Biannual Meeting
Friday, June 26
(Dearborn)

Faith and Culture Panel
Genetic Testing

Register at: moqc.org/events/

Statewide Gynecologic Oncology Tumor Board – Next

MICHIGAN ONCOLOGY QUALITY CONSORTIUM

Confidentiality Agreement

MOQC

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Cancer care. Patients first.

The best care. Everywhere.