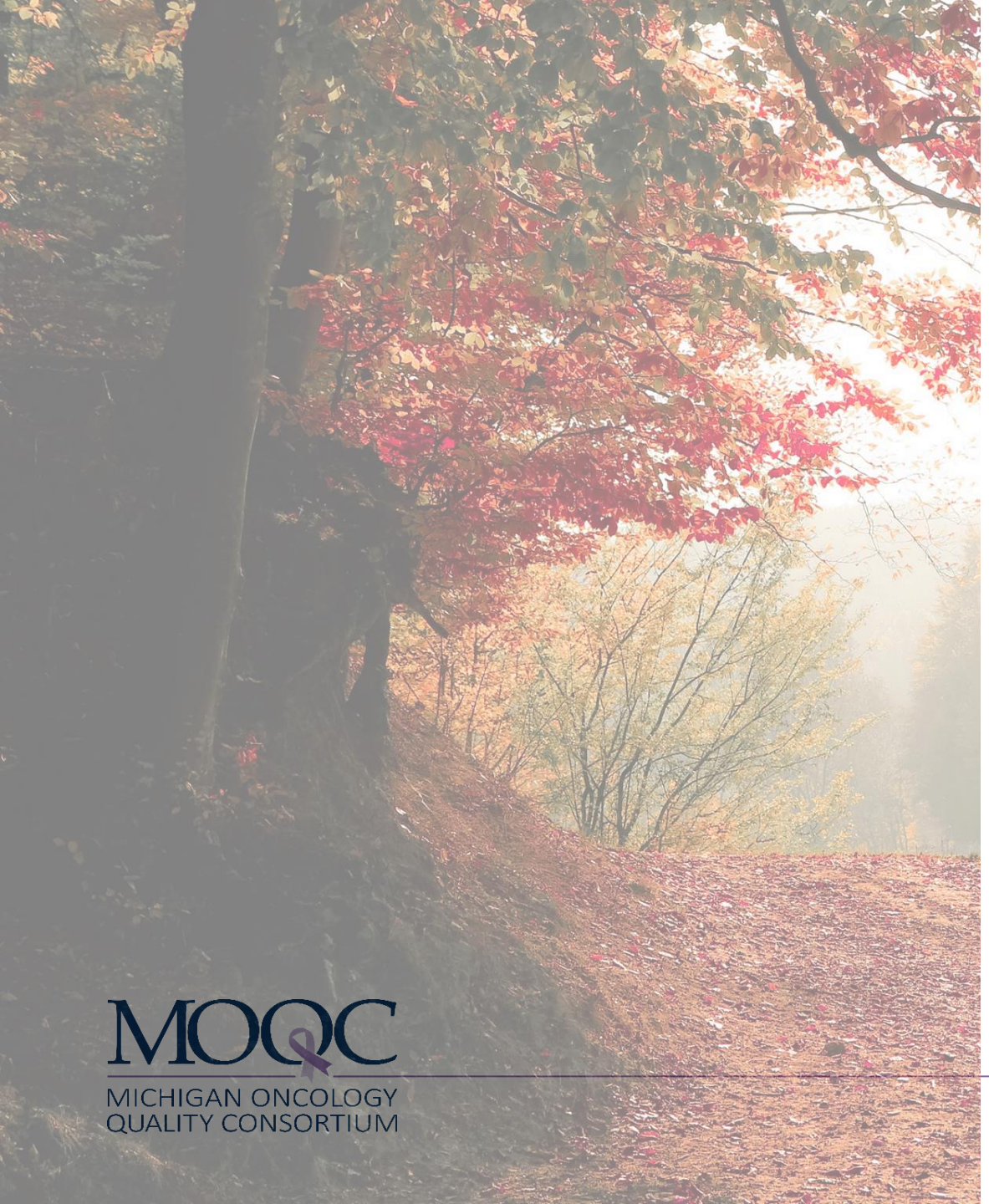

MOQC
MICHIGAN ONCOLOGY QUALITY CONSORTIUM

Gynecologic Oncology Biannual Meeting

October 7, 2023

https://moqc.org

@MOQCTeam

Welcome and Updates

Vanessa Aron, BA

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WiFi

Network: MSU Net Guest 3.0
Agree to the Terms and Conditions
No Password

Morning Agenda

TIME	TOPIC	FACILITATOR
10:00 am	**Welcome and Updates**	Vanessa Aron, BA
10:15 am	**POQC Update**	Sharon Kim, POQC
10:30 am	**Data & Updates** Participation Model Current Performance Measures & Trends – MOQC Current Performance Measures & Trends – MSQC VBR Measures and Requirements	Shitanshu Uppal, MD, MBA
11:15 am	**The State of Gynecologic Oncology in Michigan**	Bridget VandenBussche, CPHRM Anna Hoekstra, MD, MPH Shitanshu Uppal, MD, MBA
12:15 pm	**Lunch**	

Confidentiality Reminder

Taking pictures/videos of data slides is prohibited. This is a confidential professional peer review and quality assurance document of the Michigan Oncology Quality Collaborative.

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.

MOQC Print-Outs

- Agenda
- BCBS Survey
- MOQC Survey/Interprofessional Development Interest
- PROs Survey Questions

MOQC BCBS Survey

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

MOQC Initiatives

Meal Delivery Program

Cancer Drug Repository

yesRx

Patient-Reported Outcomes

Meal Delivery Update

COMFORT CUISINE

Delivering care one meal at a time

HBOM

HEALTHY BEHAVIOR OPTIMIZATION FOR MICHIGAN

MOQC

MICHIGAN ONCOLOGY QUALITY CONSORTIUM

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

Meal Delivery Update

Cancer Drug Repository

yesRx

a charitable organization founded in June 2023,

seeks to remove barriers to medication access for

vulnerable and underserved people and communities

via a State-wide Cancer Drug Repository

Removing Unreasonable Barriers to Medication Access

Insurance Restrictions

Inequitable Resources

High Co-Pays

Coverage Gaps

yesRx

2023

JUNE

Founded as agnostic charitable organization to increase medication access for vulnerable and underserved patients across Michigan

JULY

- Received 501(c)(3) designation
- Secured support from MOQC

AUGUST

Launched YesRx Network, an interconnected system of cancer drug repository programs at healthcare sites and facilities across Michigan

SEPTEMBER

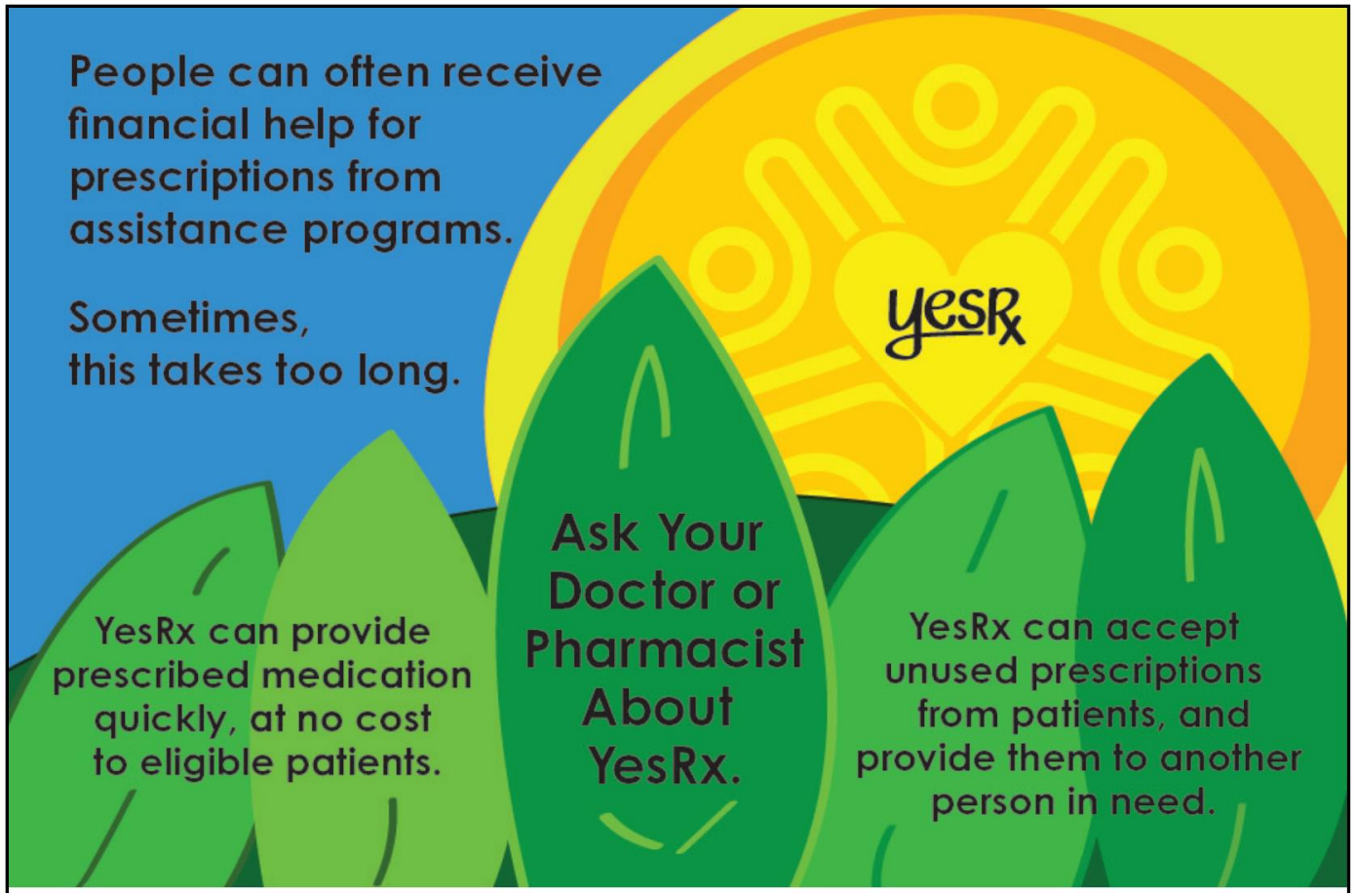
Formed strategic partnership with several major cancer centers, including Munson.

TODAY

- Receiving medication donations
- Providing medication to patients at no cost
- Onboarding new Network members
- Accepting financial donations

www.**yesrx.org**

hello@yesrx.org


People can often receive financial help for prescriptions from assistance programs.
Sometimes, this takes too long.
yesRx
Ask Your Doctor or Pharmacist About YesRx.
YesRx can provide prescribed medication quickly, at no cost to eligible patients.
YesRx can accept unused prescriptions from patients, and provide them to another person in need.

YesRx Founders

Executive leaders with clinical and business expertise committed to eliminating healthcare disparities and improving patient outcomes.

Emily Mackler PharmD, BCOP
Co-Director

Farah Jalloul PharmD, MBA
Co-Director

Siobhan Norman
Executive Director

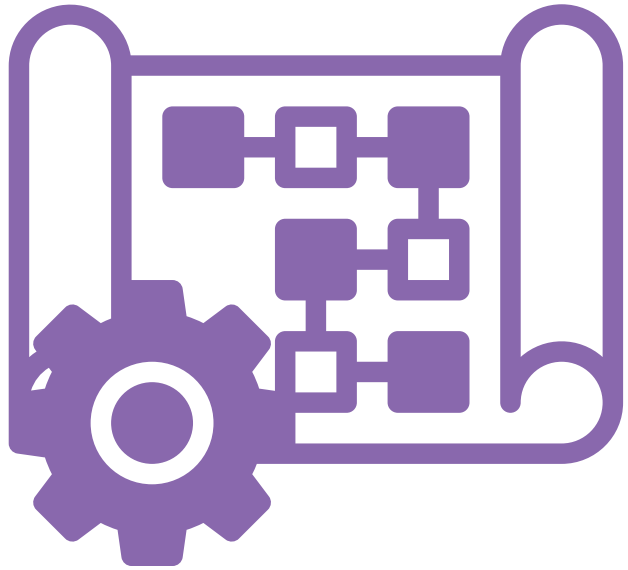
Patient-Reported Outcomes

PROs Collection

- Why are we collecting PROs?
  - Shown to increase survival for oncology patients
  - Help focus clinical interventions
  - Prioritize MOQC improvement efforts
  - Center on patient & family needs

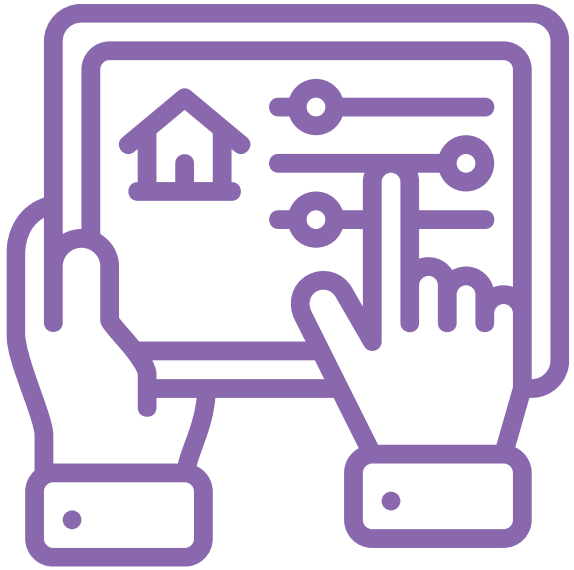
PROs Collection

- What information is being collected?
  - Symptoms
  - Social needs
  - Demographics
  - Opt-in to link PROs with clinical data
    - Analysis by diagnosis & treatment



Patient-Reported Outcomes

- 2 weeks (10 clinic days)
- MOQC-provided tablets, paper backup
- **Results are not seen by care team in real time**



Patient-reported Outcomes Data – Pilot Sites

- 3 Pilot sites
- Response Numbers
  - Total surveys attempted: 303
  - Total who met eligibility criteria: 187 (61.7%)
  - Total who completed survey: 185 (98.9%)
  - Total who provided identifying info: 148 (79.6%)

Lessons Learned from Pilot Sites

Patients care that their experiences can help future patients

- *"Not many people want to do something like fill out a survey – but nearly everyone wants to help others"*

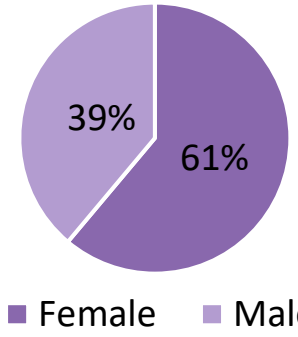
Easy-to-use Survey

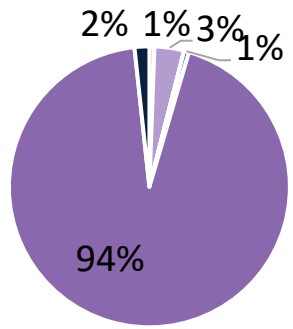
- Most completed on a tablet
- Paper backup as needed

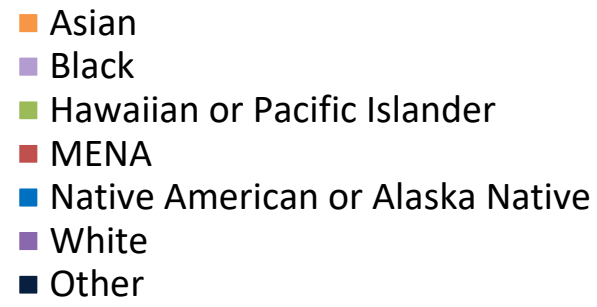
Training, materials, and support

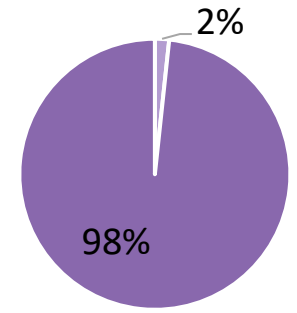
Patient-reported Outcomes Data – Pilot Sites

- Patient characteristics
  - Age
    - Avg 66.5 yrs (SD, 11.2)
    - Range [40,94]









Patient-reported Outcomes Data – Pilot Sites

Social Needs

- 33 (17.8%) of patients reported at least 1 social need
- Top social needs identified:

Lack of companionship
15 (8.1%)

In the last 12 months, ate less food b/c there wasn't enough $ for food
12 (6.5%)

In the last 12 months, needed to see a doctor but could not b/c of cost
7 (3.8%)

Patient-reported Outcomes Data – Pilot Sites

Symptoms

- 42 (22.6%) of patients rated at least 1 toxicity as frequent or almost constant
  - Top symptoms reported as frequent:
    - Anxiety
    - Sad feelings
    - Diarrhea

- 24 (12.9%) of patients rated at least 1 toxicity as severe or very severe
  - Top symptoms reported as severe (among those who reported some frequency):
    - Anxiety
    - Sad feelings
    - Neuropathic pain

Onboarding Process

- Informational meeting
- Dates reviewed and confirmed
- Virtual training for practice/infusion staff
- MOQC support

Timeline for collecting PROs

- 3 Pilot Sites Summer 2023
- 10 Additional Sites Fall/Winter 2023
- Remaining MOQC sites Winter/Spring 2024

The PROs Team

Chris Friese, PhD, RN

Director,
Patient-Reported
Outcomes

Shayna Weiner, MPH

Project Manager

Ashley Bowen, MS, RD

Project Manager

Questions

POQC Updates

Sharon Kim, POQC

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Financial Navigation

Recruitment & Retention

Patient & Caregiver Resources

paf Patient Advocate Foundation

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Financial Navigation

Phase 1-Year 1

- Connect with three practices
- Document current state of screening /referral processes for social and financial needs
- Identify gaps
- Review best practice standards

Phase 2-Years 2 & 3

- Document suggestions of new practice-specific processes
- Integrate new approaches into clinical workflow
- Identify quality metrics
- Measure performance/satisfaction
- Use iterative/PDCA model

paf
Patient Advocate Foundation

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Recruitment and Retention Workgroup

2023 Recruitment Focus

Historically Marginalized Populations in Healthcare

- **Race/Ethnicity Minority Status**
- **LGBTQIA+**
  - Gender Identity
  - Sexual Orientation
- **Armed Services Experience**
- **Disability**

Underrepresented Numbers in POQC

- **Cancer Type**
- Partnership Status During Treatment
- Cancer Designation
  (Newly diagnosed, etc.)
- Current Age
- Diagnosis Age

Financial Navigation

Recruitment & Retention

Patient & Caregiver Resources

paf Patient Advocate Foundation

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Patient and Caregiver Resources

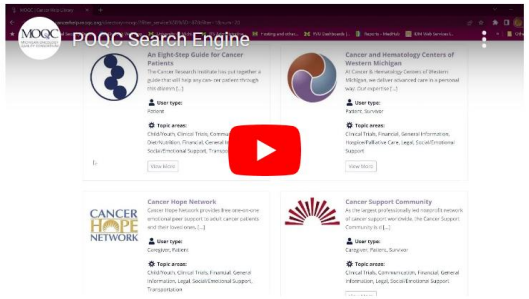
Search Engine

Resources Search Engine

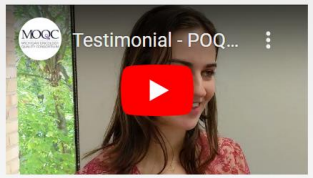
Cancer has a huge impact on patients and their families, friends and other caregivers. Use this search engine to help find answers, guidance, and support.

MOQC is always working to gather and share resources that are important for anyone touched by cancer.

For help navigating this search engine, view our instructional video:



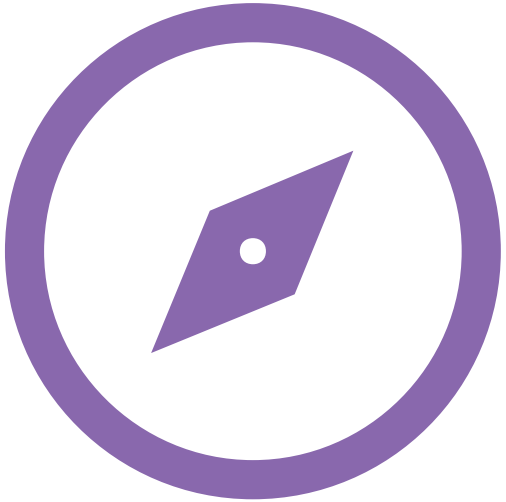
TESTIMONIAL:



More on the Affordable Care Act (ACA) at HealthCare.gov

Search Engine Feedback?

Caregiver Navigation



How Are We Doing?
Data & Updates

Shitanshu Uppal, MD, MBA

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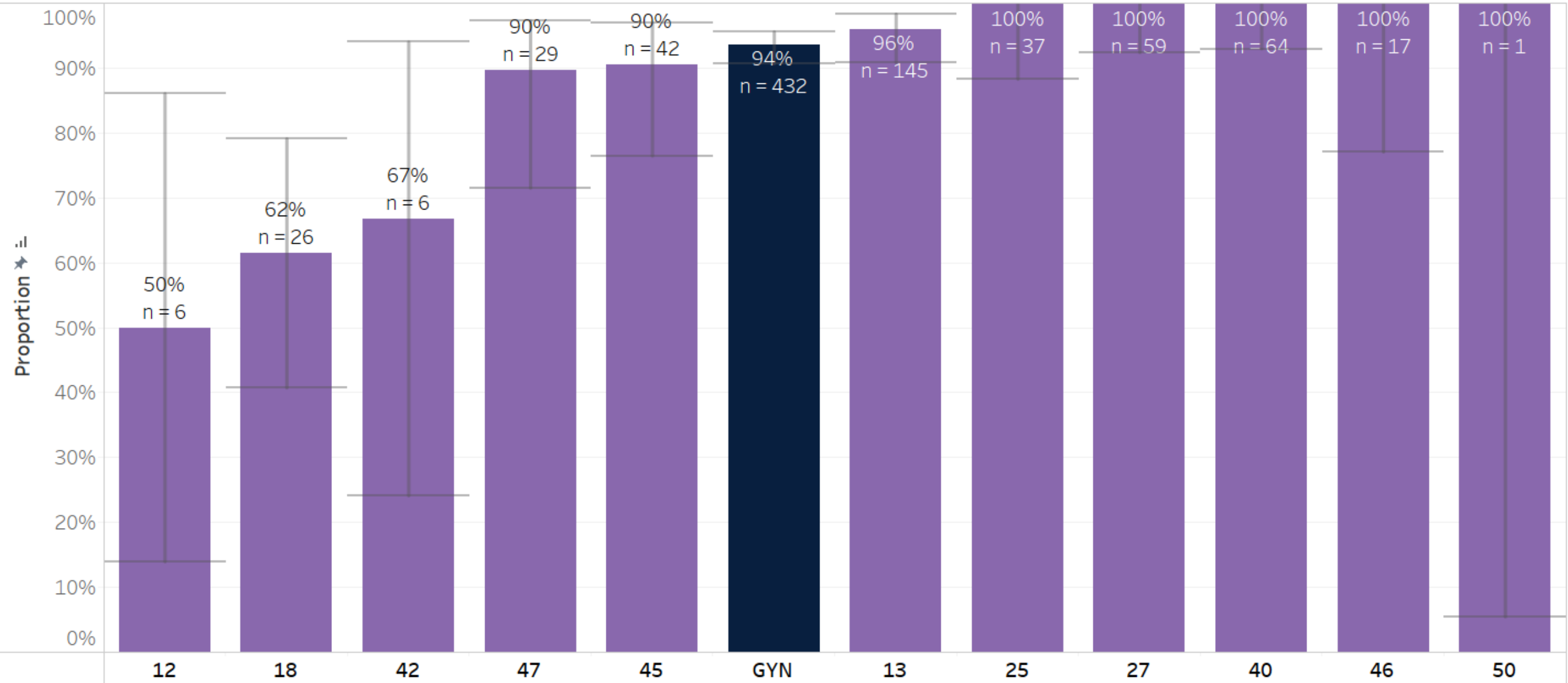
Practices with no eligible cases in the denominator and/or missing data from one of the time periods are not shown

MOQC Gynecologic Oncology Measures

MOQC Pathway	
104	Chemotherapy intent (curative vs non-curative) documented before or within 2 weeks after administration)
114	NK1 receptor antagonist for low or moderate emetic risk cycle 1 chemotherapy (lower score – better)
115	NK1 receptor antagonist and olanzapine prescribed or administered with high emetic risk chemotherapy
111	GCSF administered to patients who received chemotherapy for non-curative intent
126a	Hospice enrollment
126b	Enrolled in hospice for over 7 days
126c	Enrolled in hospice for over 30 days
127	Chemotherapy administered within the last 2 weeks of life

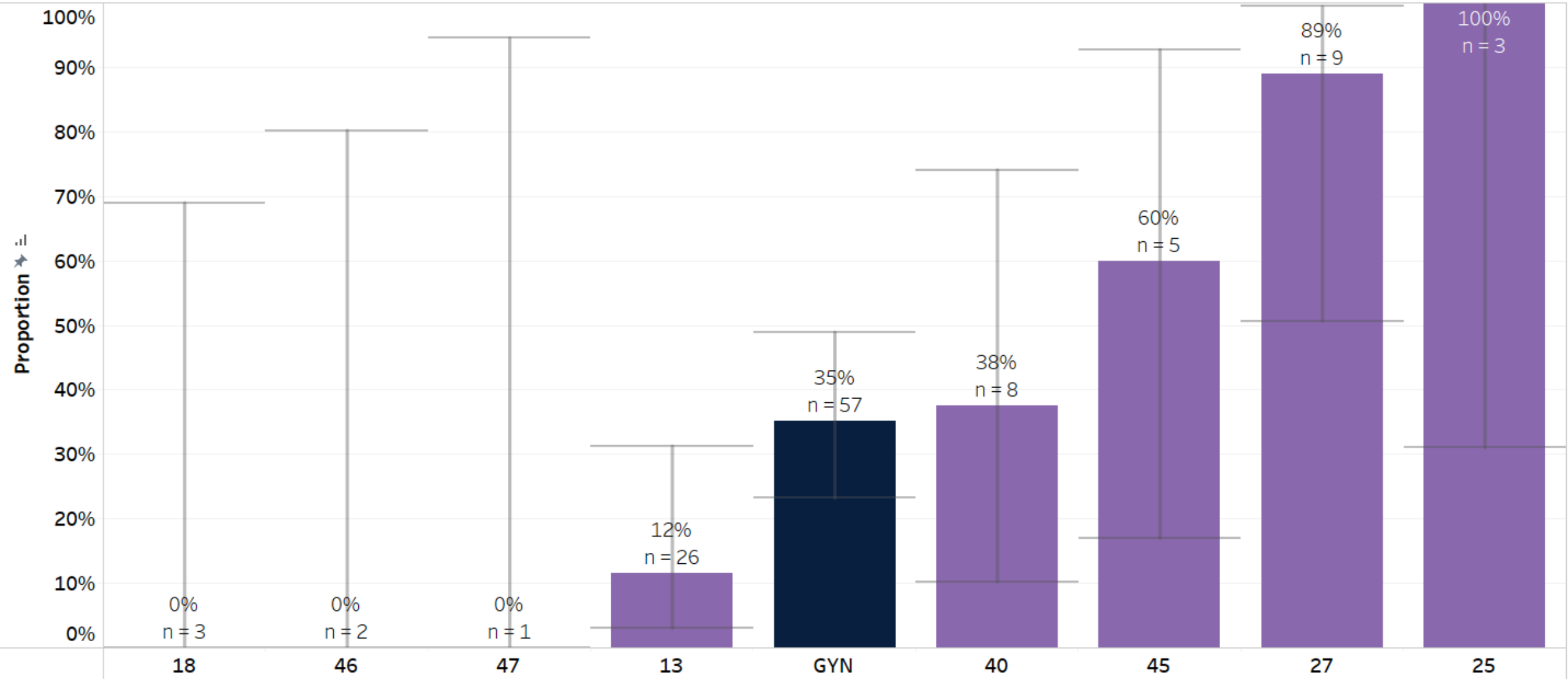
Targeted Measures		Target
101b	Tobacco cessation counseling administered or patient referred in the past year	70%
108a	Complete family history document for patients with invasive cancer	35%
123	Days from debulking surgery to chemotherapy	28 days

104: Chemotherapy Intent (Curative Vs. Non-Curative) Documented Before or Within Two Weeks After Administration
R2 2022 & R1 2023, n = 432

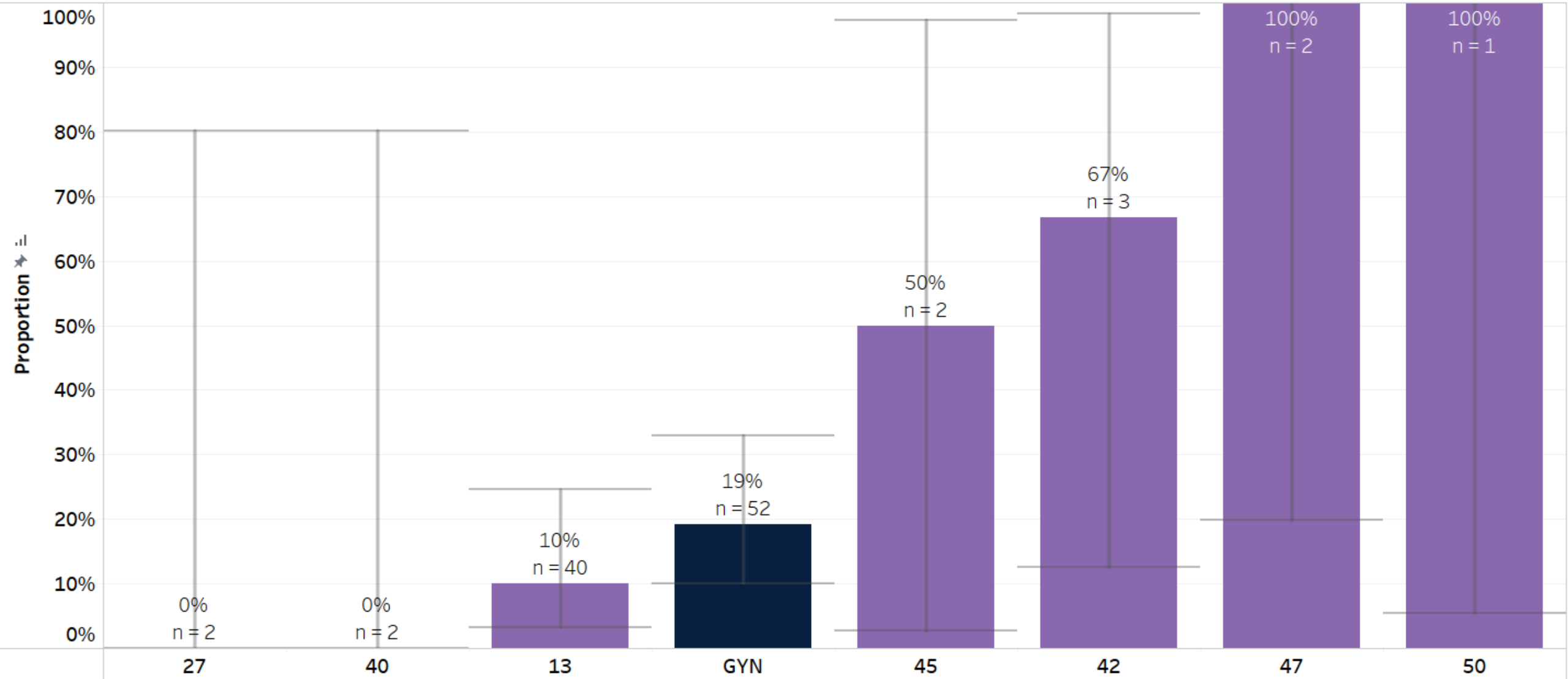


115: NK1 Receptor Antagonist and Olanzapine Prescribed or Administered with High Emetic Risk Chemotherapy

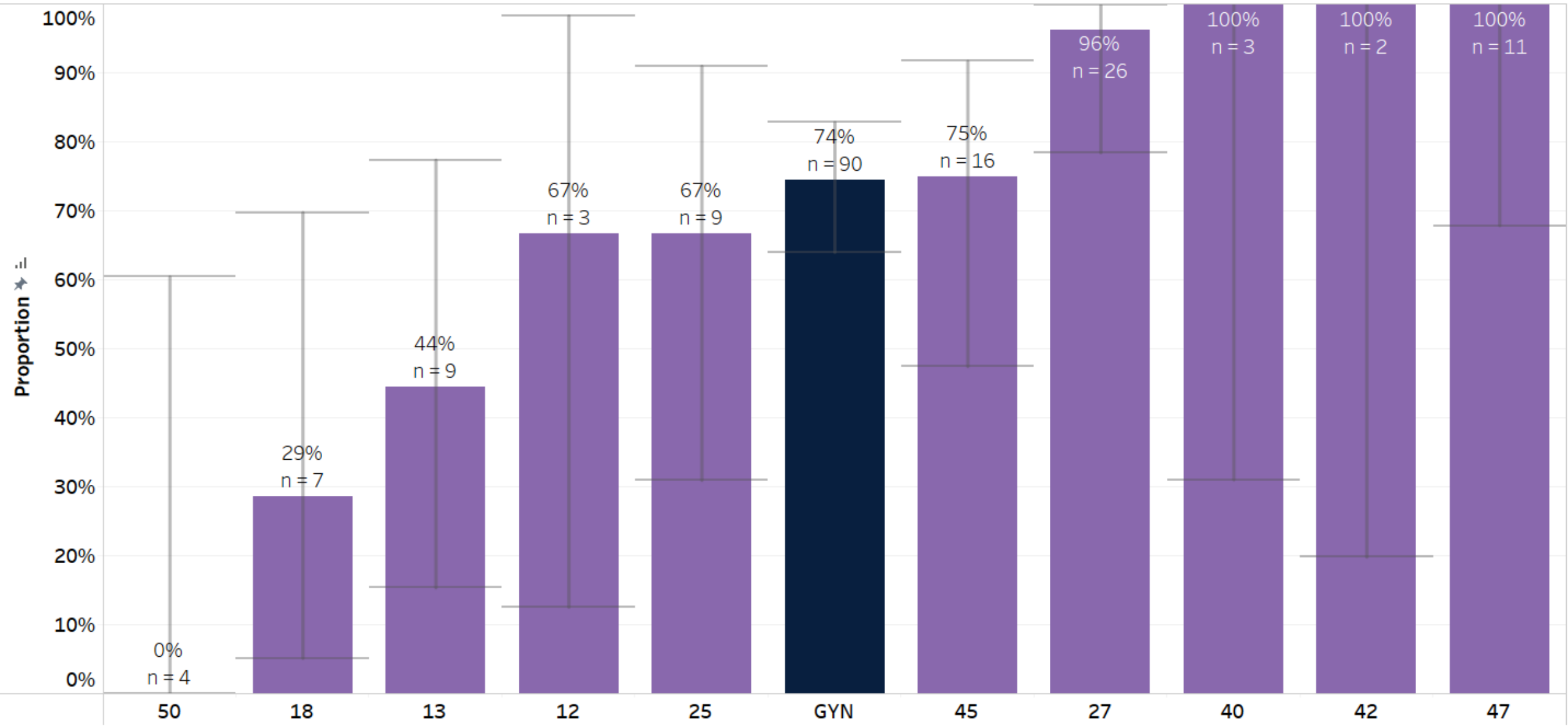
R2 2022 & R1 2023, n = 57



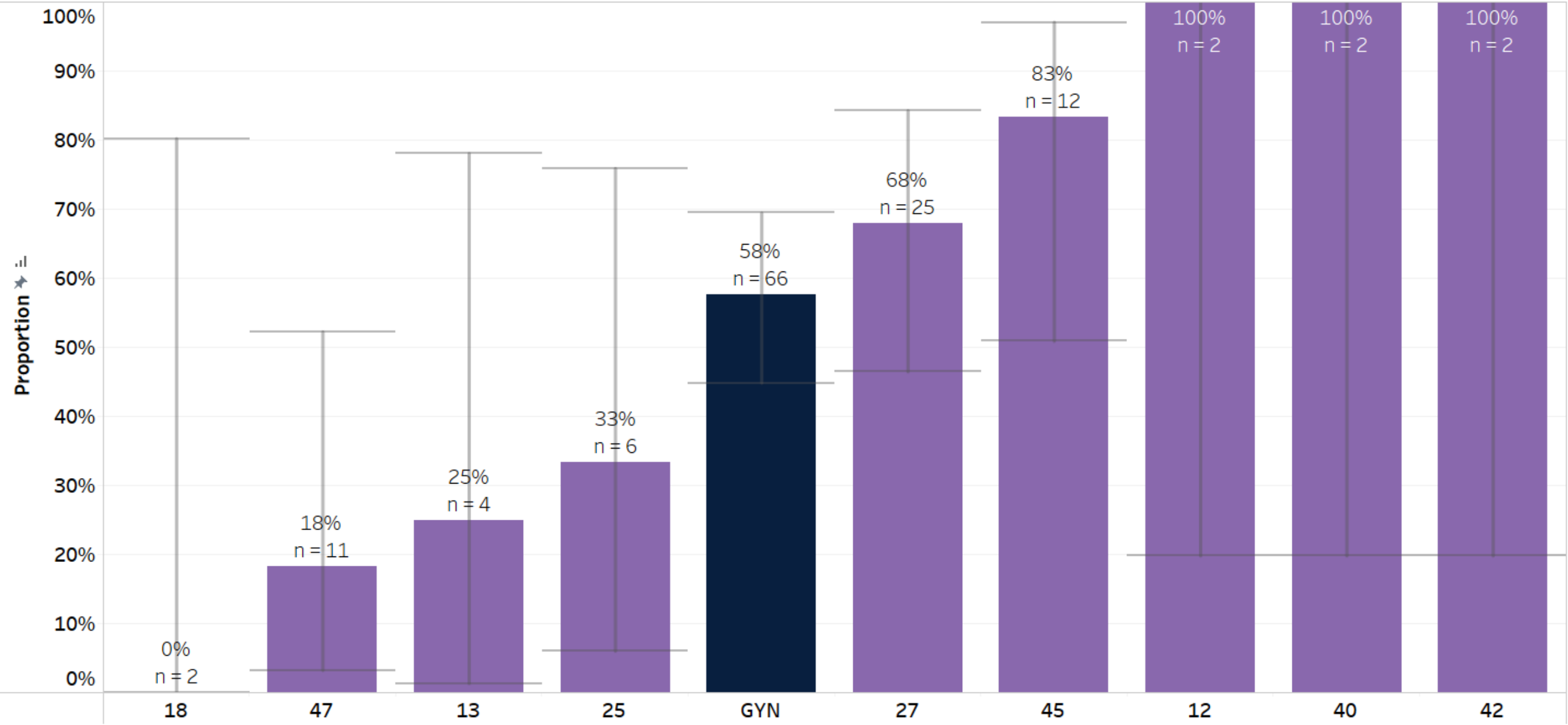
111: GCSF Administered to Patients who Received Chemotherapy for Non-Curative Intent (Lower-Score Better)
R2 2022 & R1 2023, n = 52



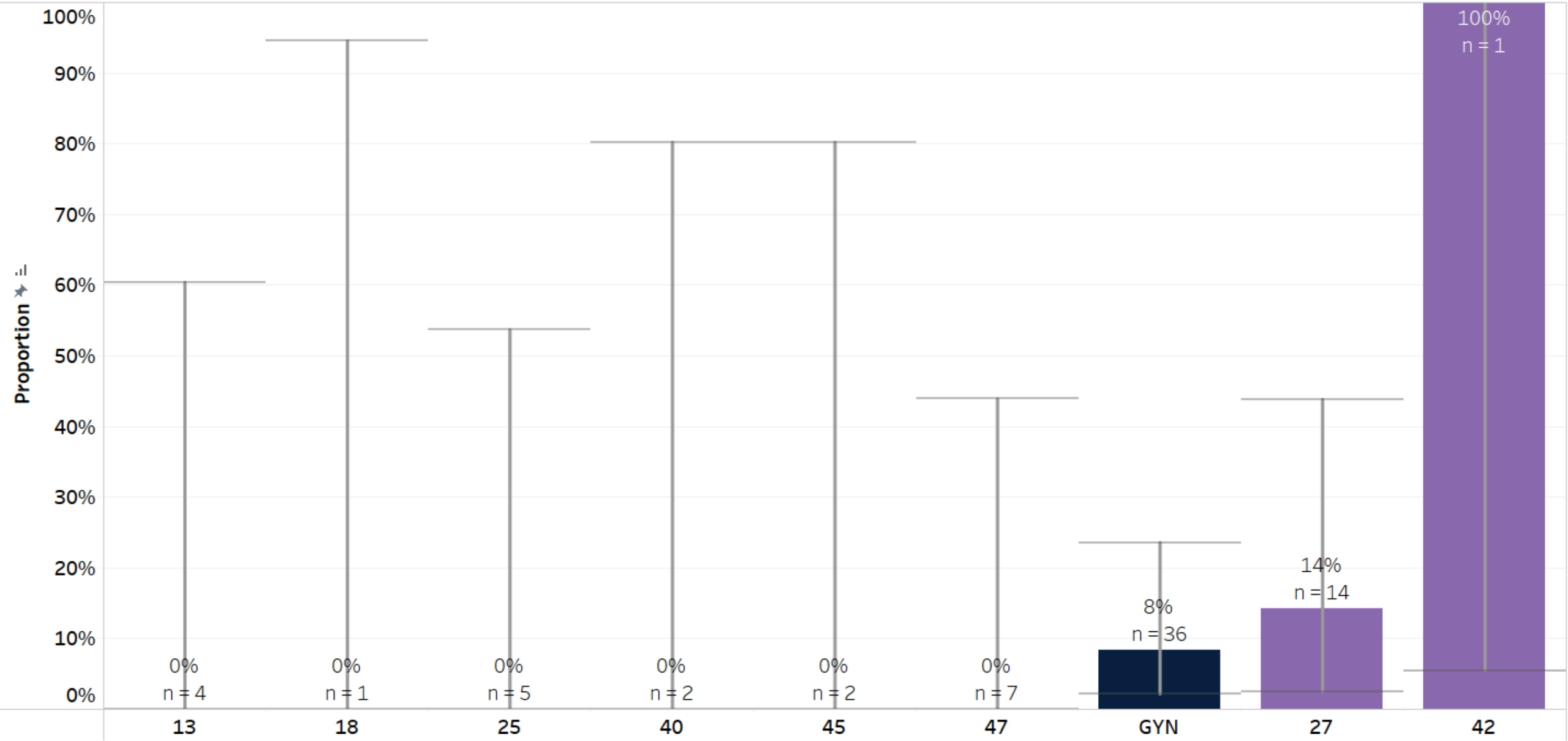
126a: Hospice Enrollment
R2 2022 & R1 2023, n = 90



126b: Hospice Enrollment More than 7 Days Before Death
R2 2022 & R1 2023, n = 66

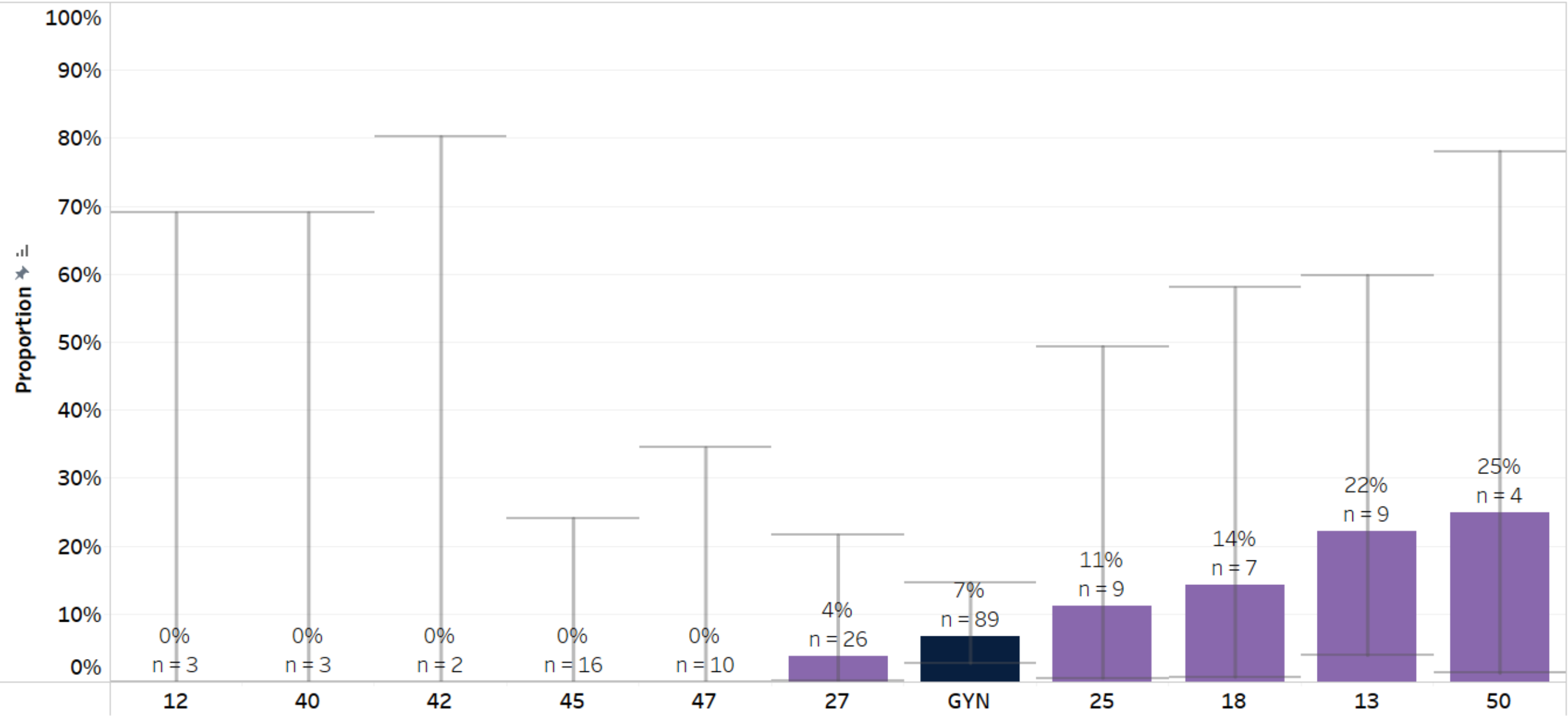


126c: Hospice Enrollment More than 30 Days Before Death*
R2 2022 & R1 2023, n = 36

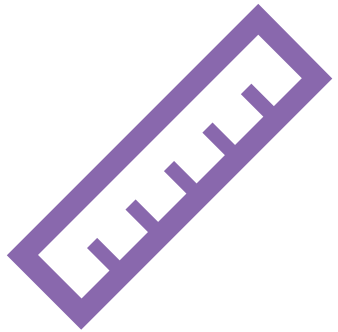


*MOQCLink data only

127: Chemotherapy Administered Within the Last 2 Weeks of Life (Lower-Score Better)
R2 2022 & R1 2023, n = 89



MSQC Gynecologic Oncology Measures



MSQC Gynecologic Oncology Measures

MOQC Pathway
Emergency room utilization
Readmission rates
Reoperation rates
Serious complications
Surgical site infections
Urinary tract infections
Venous thromboembolism

MOQC Pathway		Target
116	Outpatient prescribing of opioids for patients after laparoscopic or open hysterectomy	9 pills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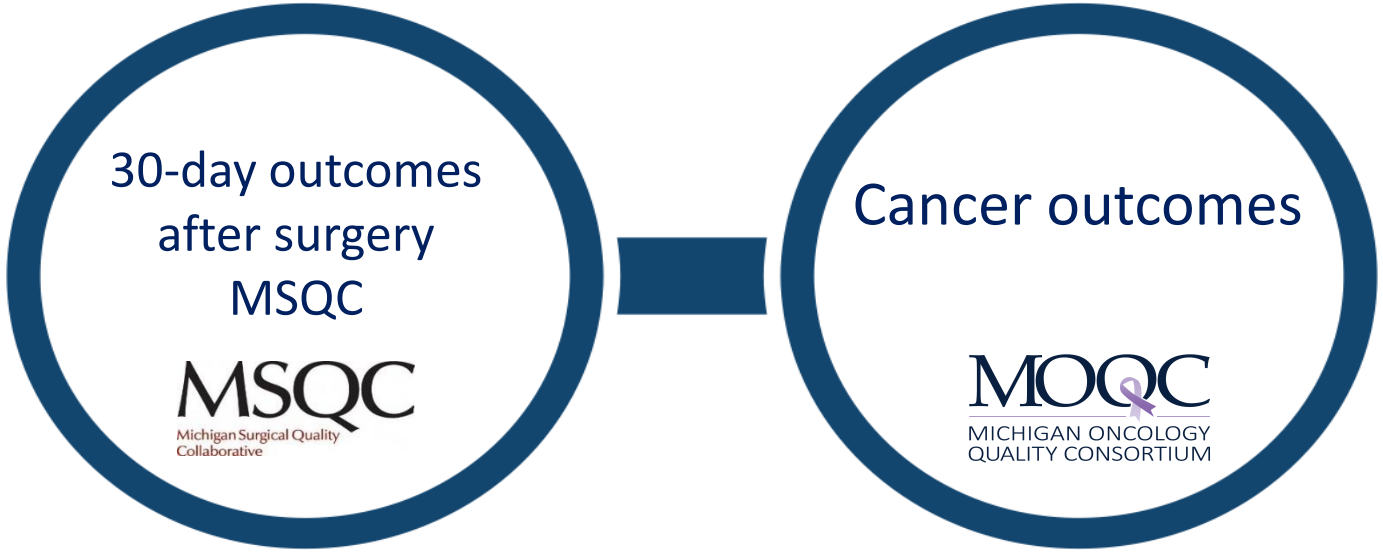
MSQC
Michigan Surgical Quality
Collaborative


30-day outcomes
after surgery
MSQC
MSQC
Michigan Surgical Quality
Collaborative
Cancer outcomes
MOQC
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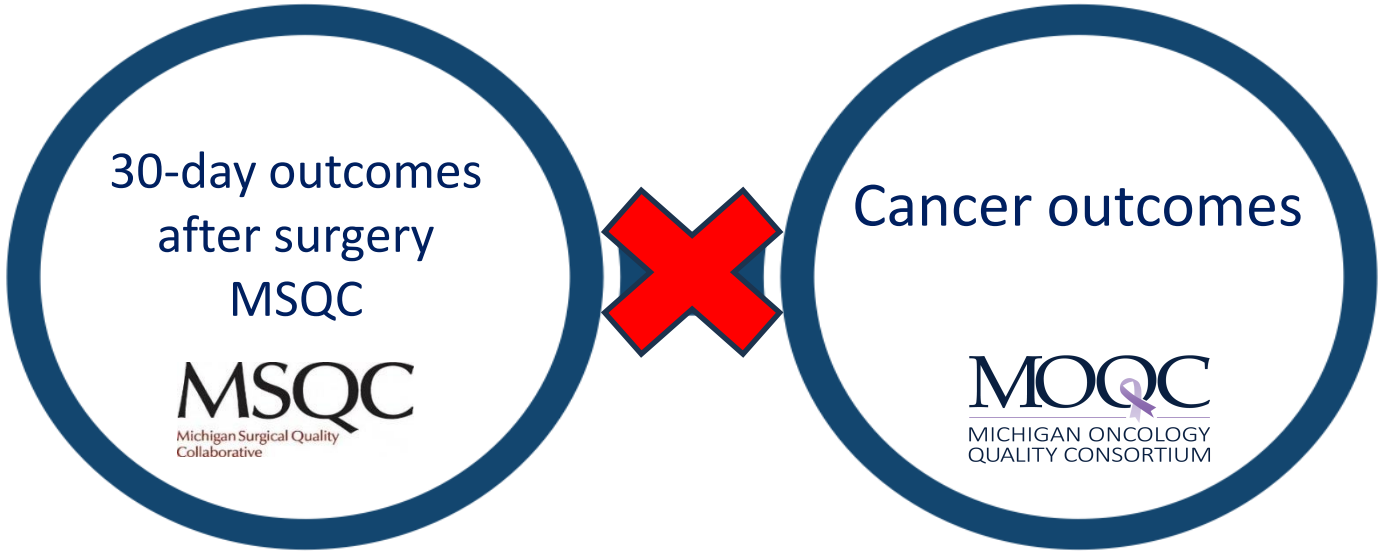
2024


30-day outcomes
after surgery
MSQC
MSQC
Michigan Surgical Quality Collaborative
Cancer outcomes
MOQC
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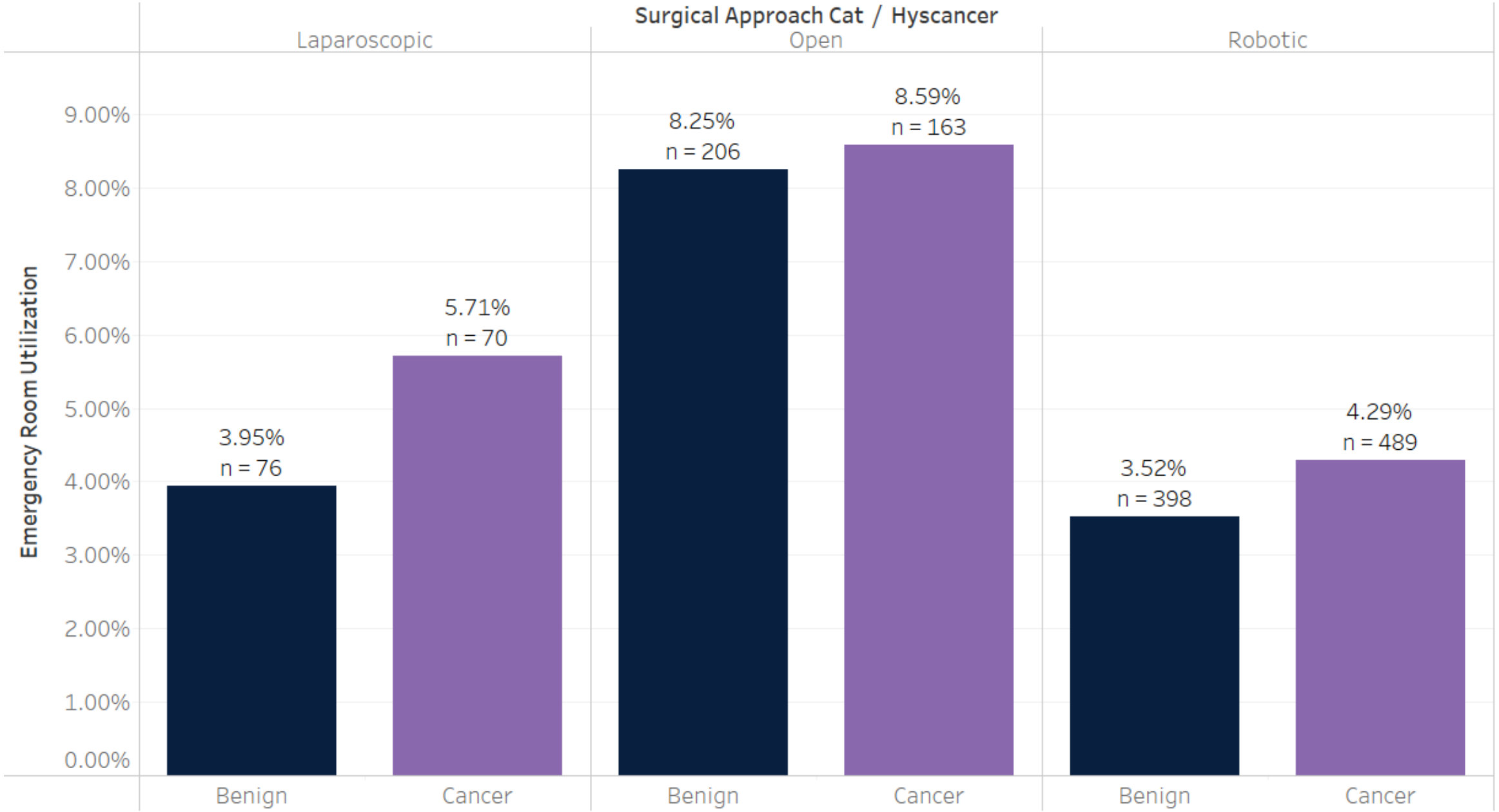
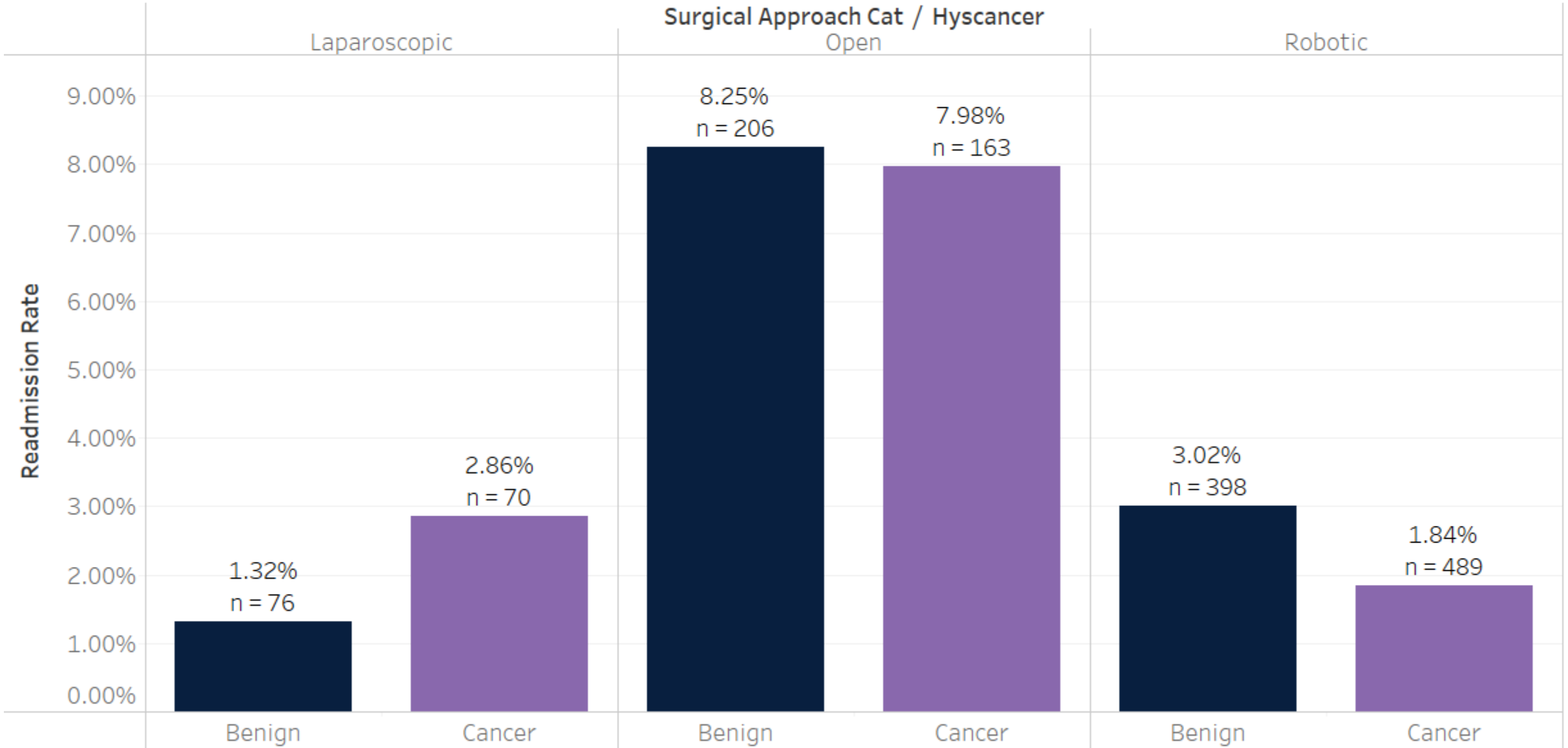
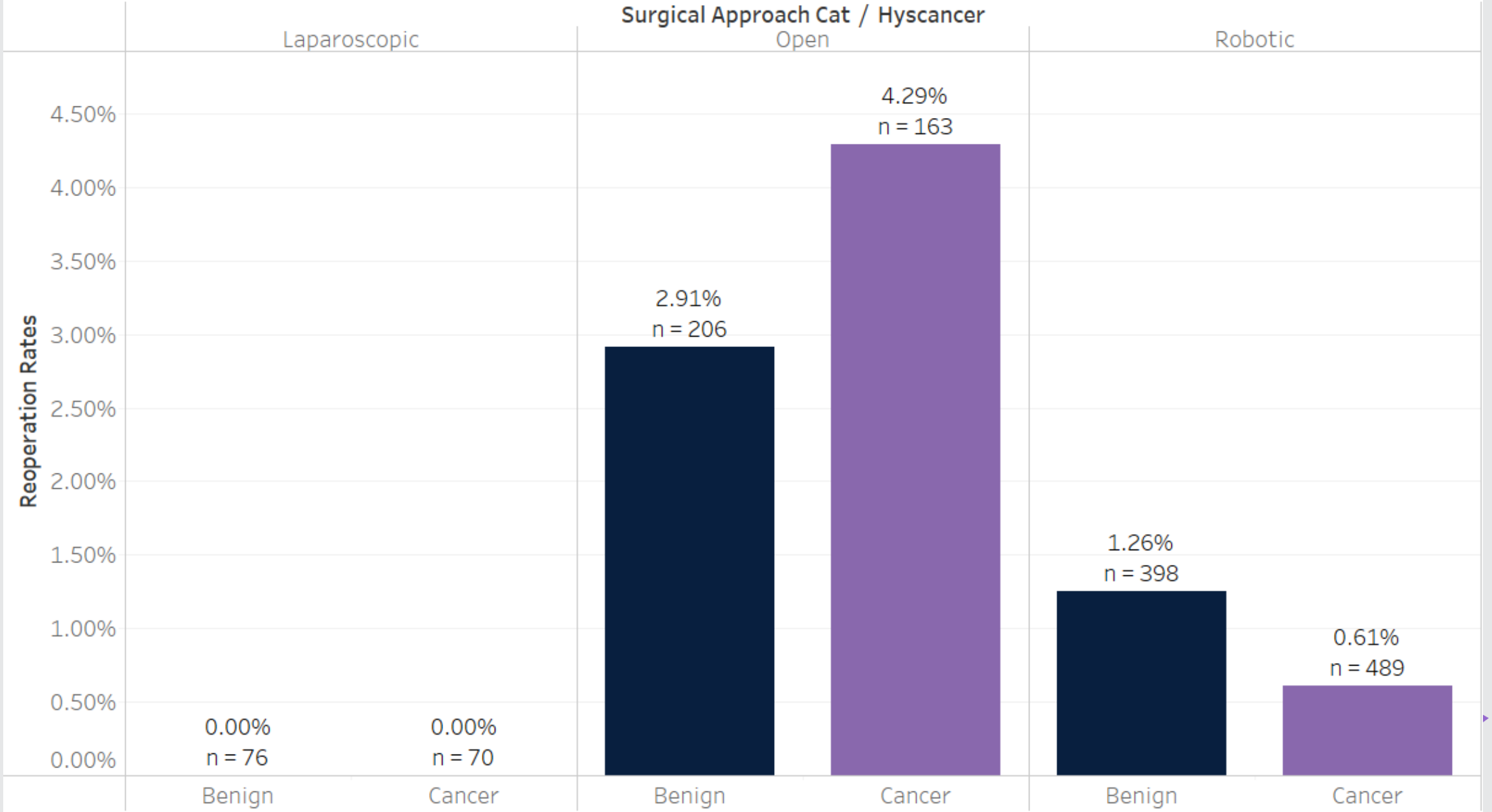
Emergency Room Utilization
5/1/22 - 4/30/23, n = 1,402



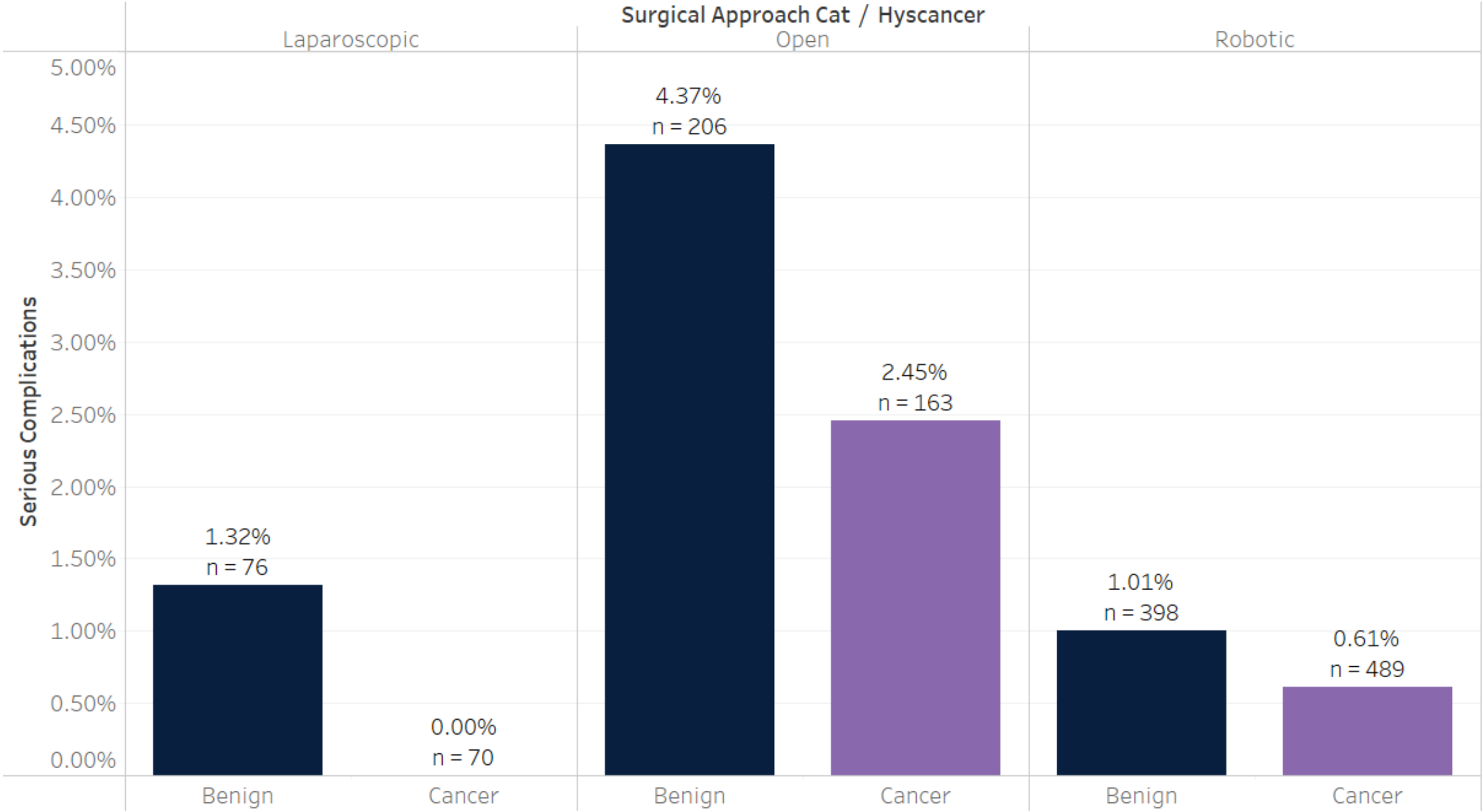
Readmission Rates
5/1/22 - 4/30/23, n = 1,402



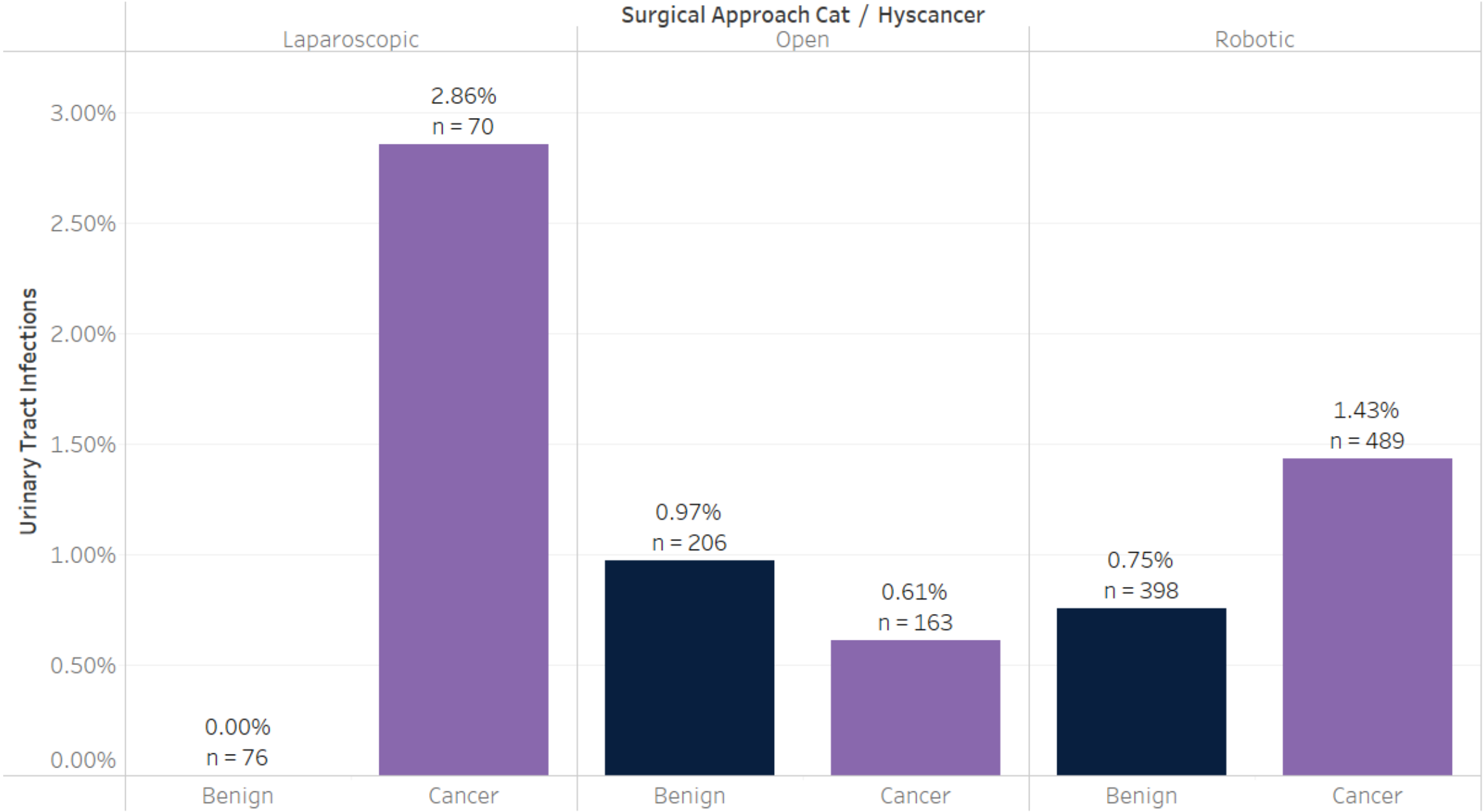
Reoperation Rates
5/1/22 - 4/30/23, n = 1,402



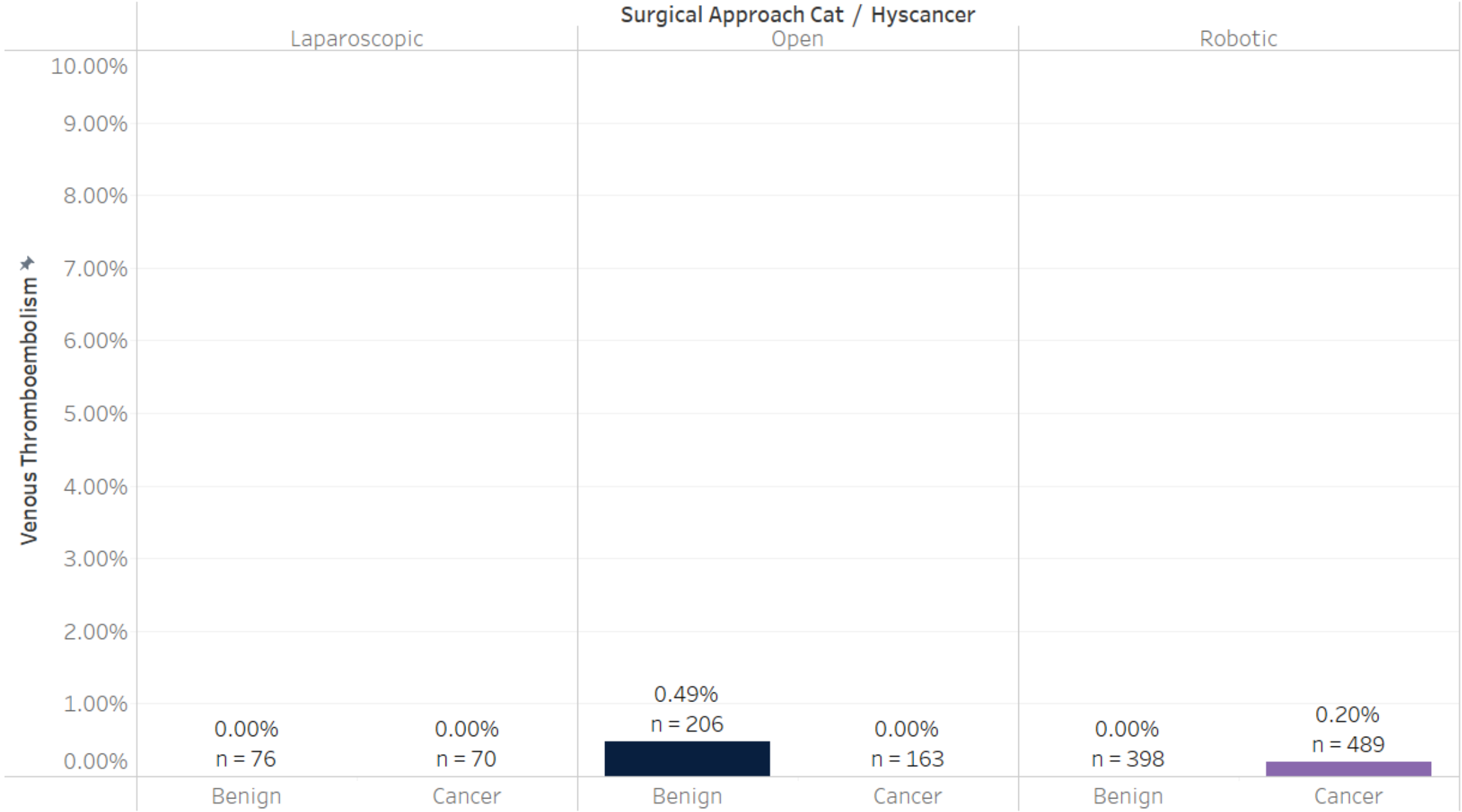
Serious Complications
5/1/22 - 4/30/23, n = 1,402



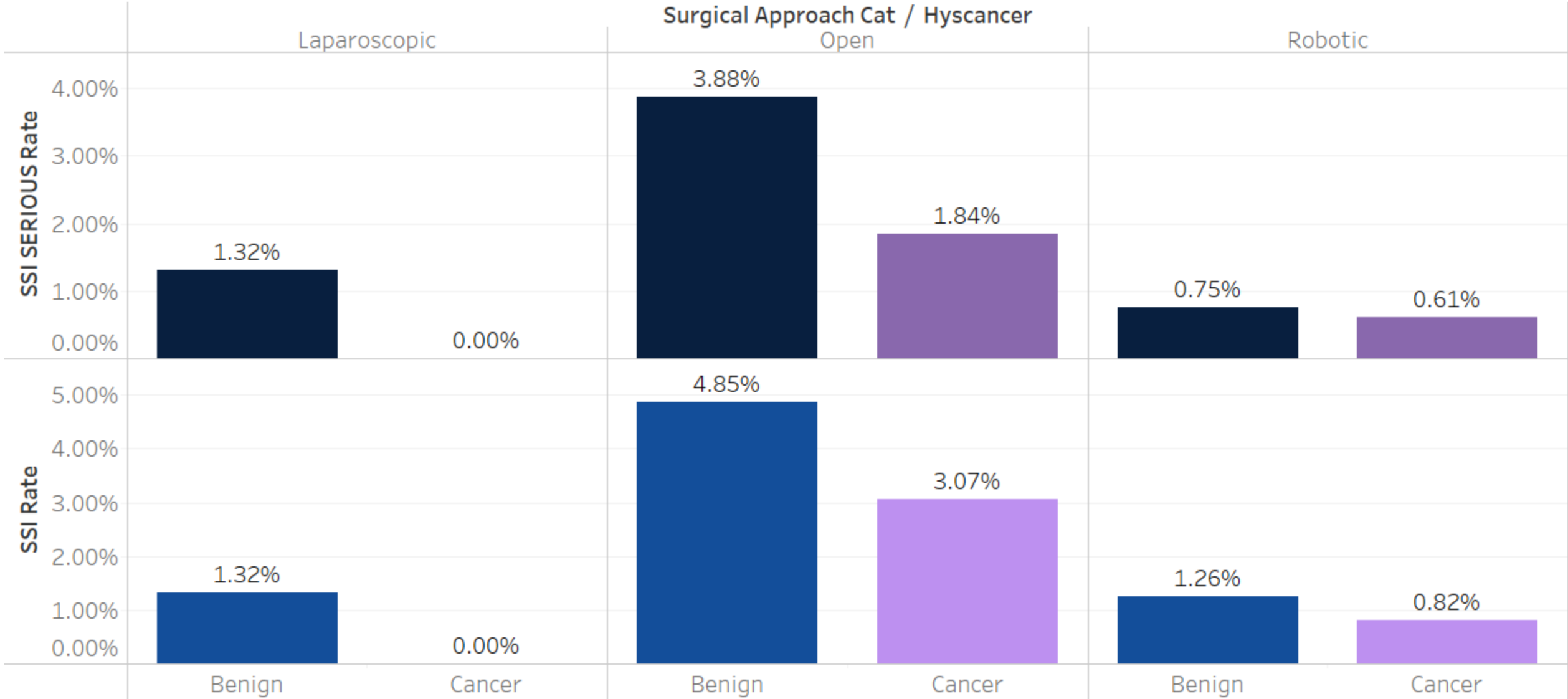
Urinary Tract Infections
5/1/22 - 4/30/23, n = 1,402



Venous Thromboembolism
5/1/22 - 4/30/23, n = 1,402



Surgical Site Infections
5/1/22 - 4/30/23, n = 1,402



Fee Schedule Increase Opportunities

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Participation to Qualify for Fee Schedule Increases

Points Needed: 100		
Meeting Participation	**Points***	**Notes**
Gynecologic Oncology Spring 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**.
Gynecologic Oncology Spring Biannual Meeting **Administrative Champion**	25	
Gynecologic Oncology Fall Biannual Meeting **Physician Champion**	25	
Gynecologic Oncology Fall Biannual Meeting **Administrative Champion**	25	

*maximum of 50 points per meeting, 25 for Physician Champion and 25 for Administrative Champion

Participation to Qualify for Fee Schedule Increases

Points Needed: 100		
Additional Participation	**Points**	**Description**
MiGHT	40	Participate and actively use family health history tool
POEM	40	Participate with a POEM pharmacist
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
Presentation at a MOQC Biannual Meeting	20	Gynecologic oncology or medical oncology biannual meetings
Participation with MOQC newsletter	10	Practice spotlight interview, article about best practices, etc.

2023 Fee Schedule Increase Summary

Tobacco Cessation Opportunity	
Collaborative-Wide (with Med Onc)	
Tobacco cessation counseling administered or patient referred in the past year	70%
2% Opportunity	

VBR Measure Opportunity	
Collaborative-Wide - Meet Both	
Days from debulking surgery to chemotherapy start	28 days
Outpatient prescribing of opioids for patients after laparoscopic or open hysterectomy	9 pills
3% Opportunity	

Complete Family History Opportunity	
Practice - Meet Both	
Meet VBR measures	2
Complete family history documented for patients with invasive cancer	35%
Additional 2% Opportunity	

Total eligibility: up to 7%

Tobacco Cessation Opportunity

2023 Fee Schedule Increase Summary

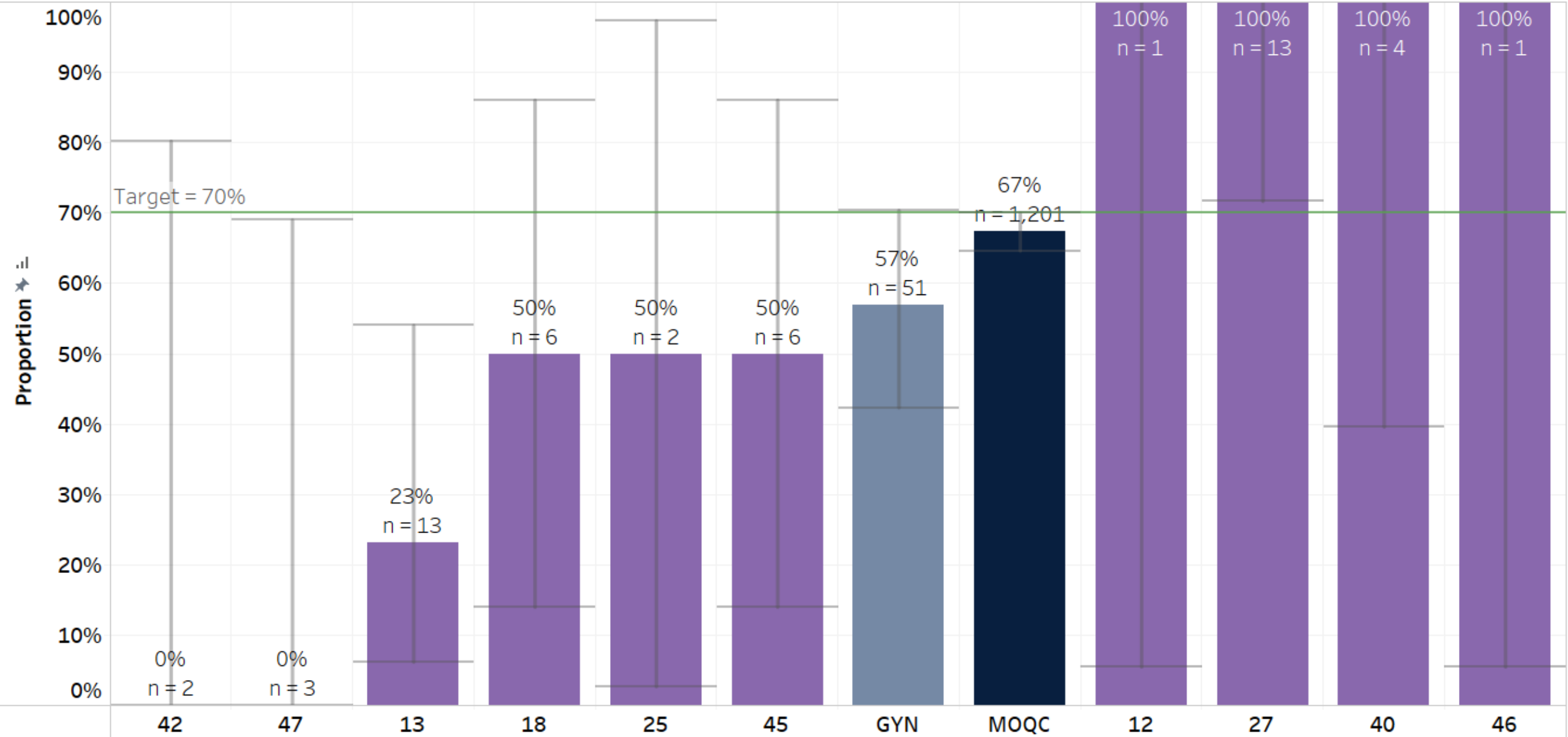
Tobacco Cessation Opportunity	
Collaborative-Wide (with Med Onc)	
Tobacco cessation counseling administered or patient referred in the past year	70%
2% Opportunity	

Gynecologic Oncology Target Opportunity	
Collaborative-Wide - Meet 2	
Days from debulking surgery to chemotherapy start	28 days
Outpatient prescribing of opioids for patients after laparoscopic or open hysterectomy	9 pills
3% Opportunity	

Complete Family History Opportunity	
Practice Meet Both	
Meet VBR measures	2
Complete family history documented for patients with invasive cancer	35%
Additional 2% Opportunity	

Total eligibility: up to 7%

101b: Tobacco Cessation Counseling Administered or Patient Referred in Past Year
R2 2022 & R1 2023, n = 51



Gynecologic Oncology Target Opportunity

2023 Fee Schedule Increase Summary

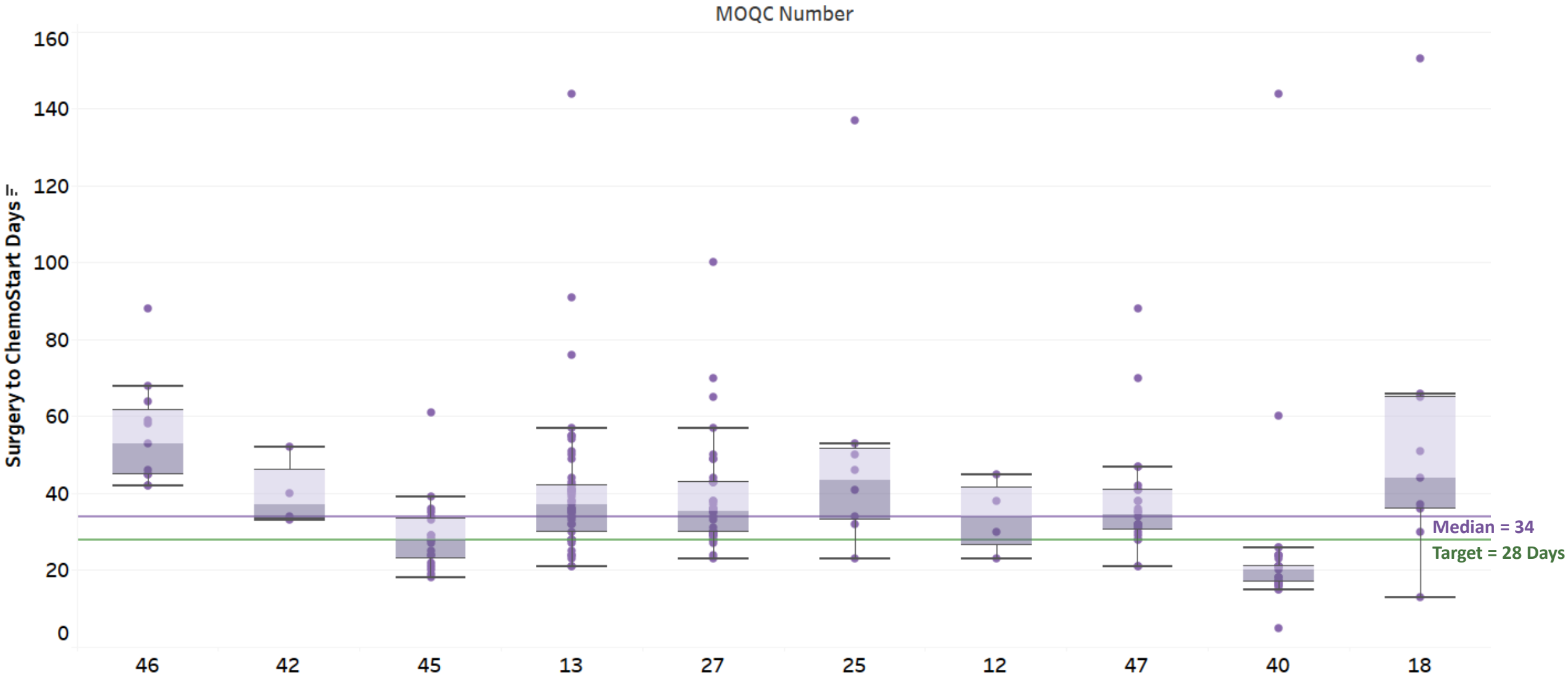
Tobacco Cessation Opportunity	
Collaborative-Wide (with Med Onc)	
Tobacco cessation counseling administered or patient referred in the past year	70%
2% Opportunity	

Gynecologic Oncology Target Opportunity	
Collaborative-Wide - Meet 2	
Days from debulking surgery to chemotherapy start	28 days
Outpatient prescribing of opioids for patients after laparoscopic or open hysterectomy	9 pills
3% Opportunity	

Complete Family History Opportunity	
Practice Meet Both	
Meet VBR measures	2
Complete family history documented for patients with invasive cancer	35%
Additional 2% Opportunity	

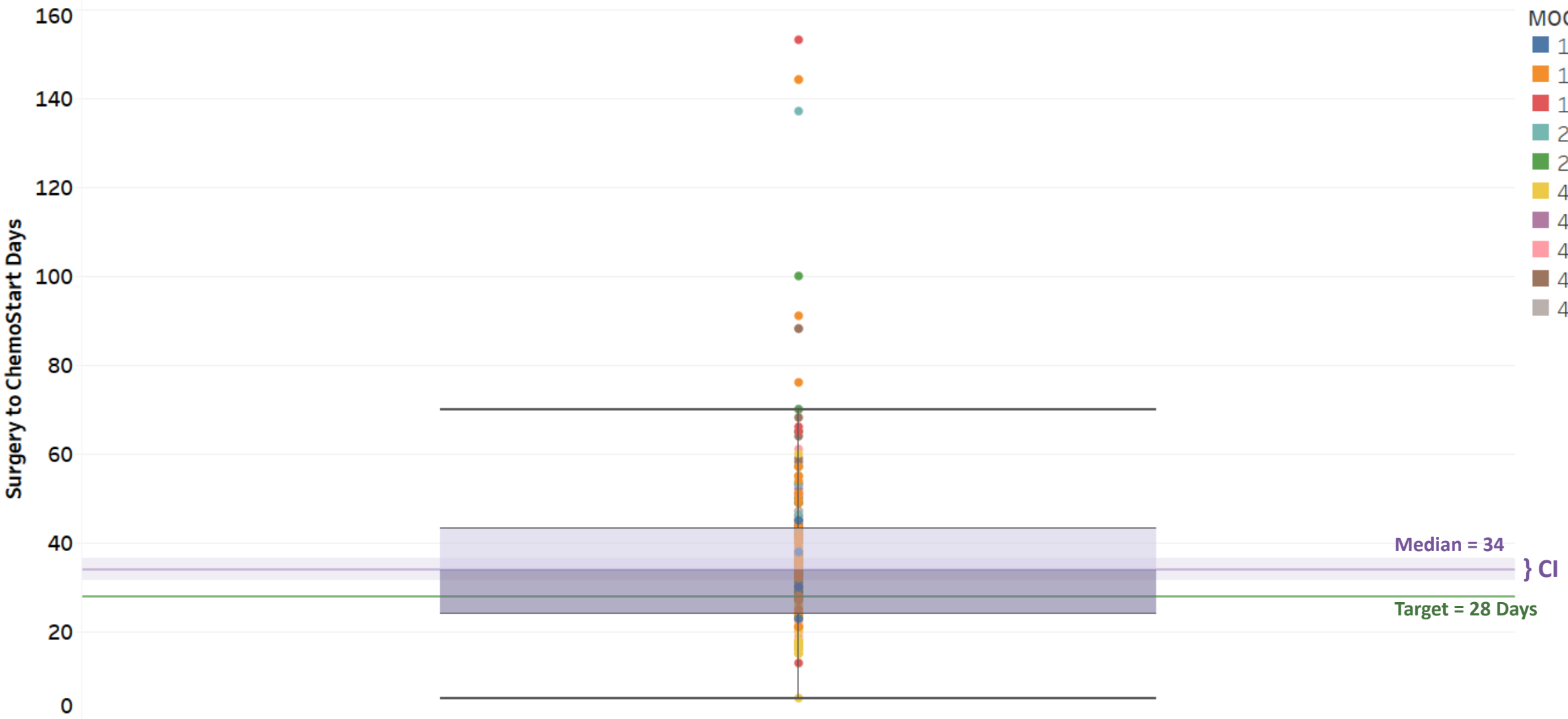
Total eligibility: up to 7%

123: Days From Debulking Surgery to Chemotherapy Start, by Practice (Lower Score - Better)
R2 2022 & R1 2023, n = 198

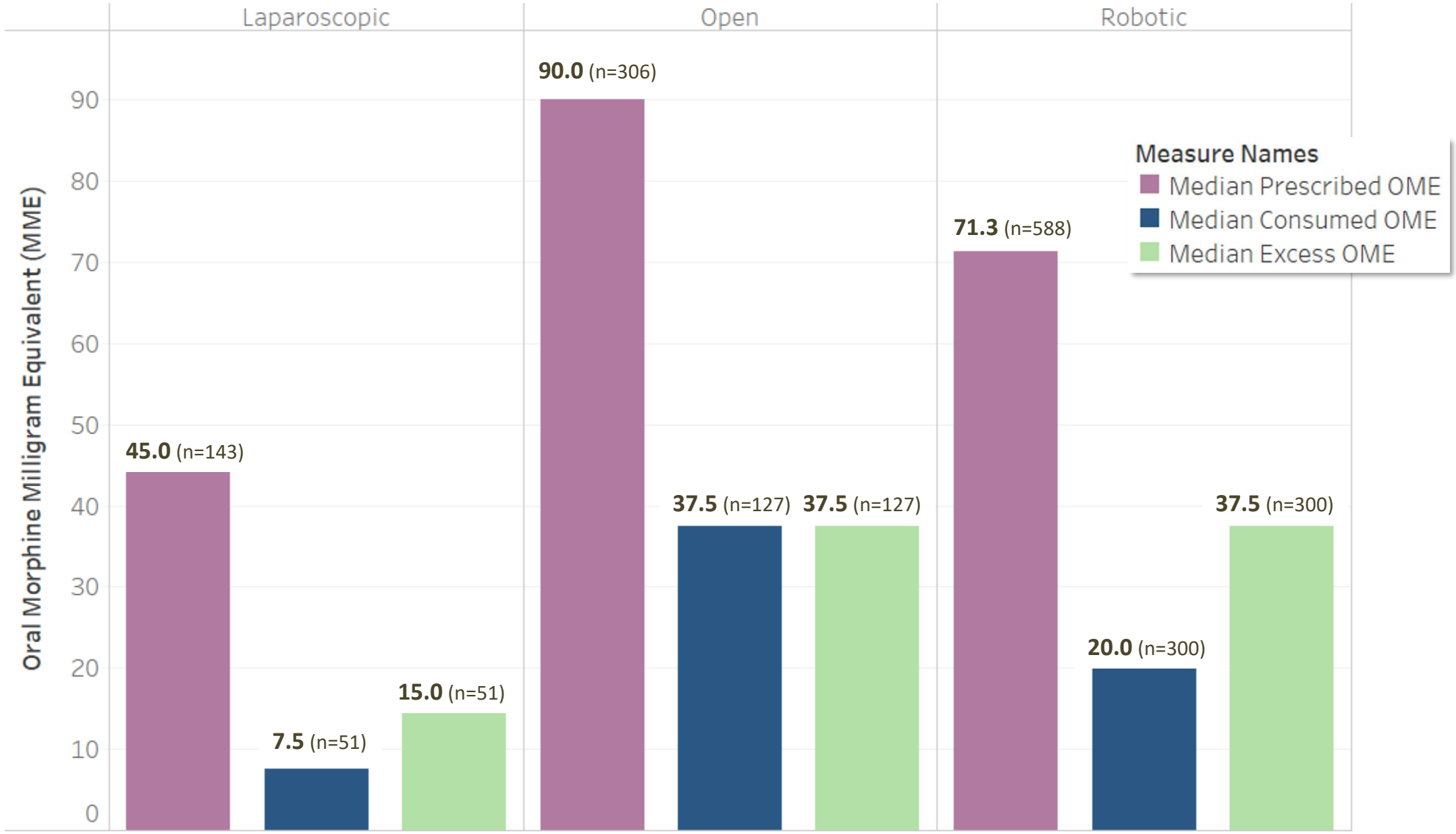


123: Days From Debulking Surgery to Chemotherapy Start, All Practices (Lower Score - Better)

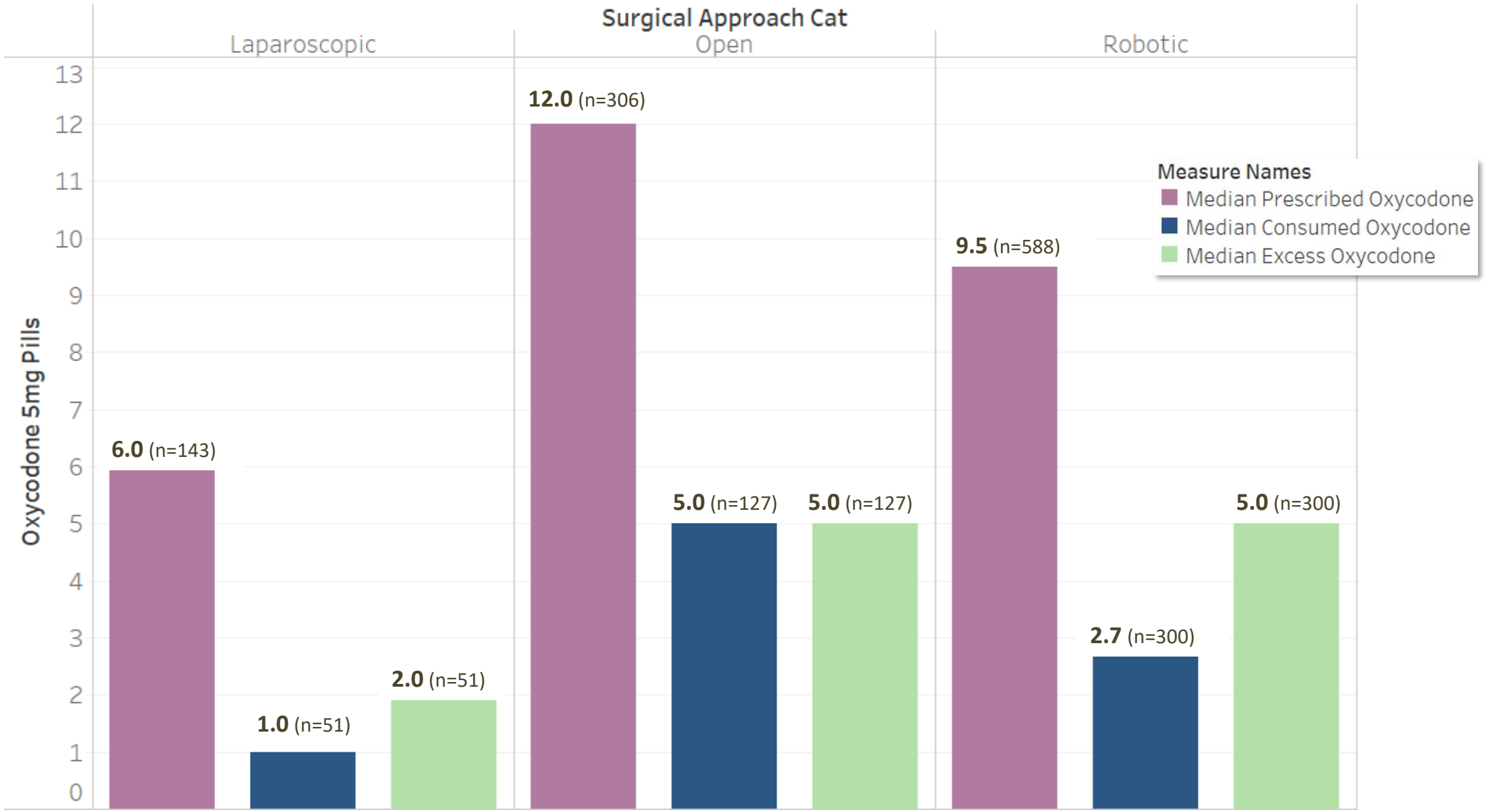
R2 2022 & R1 2023, n = 198



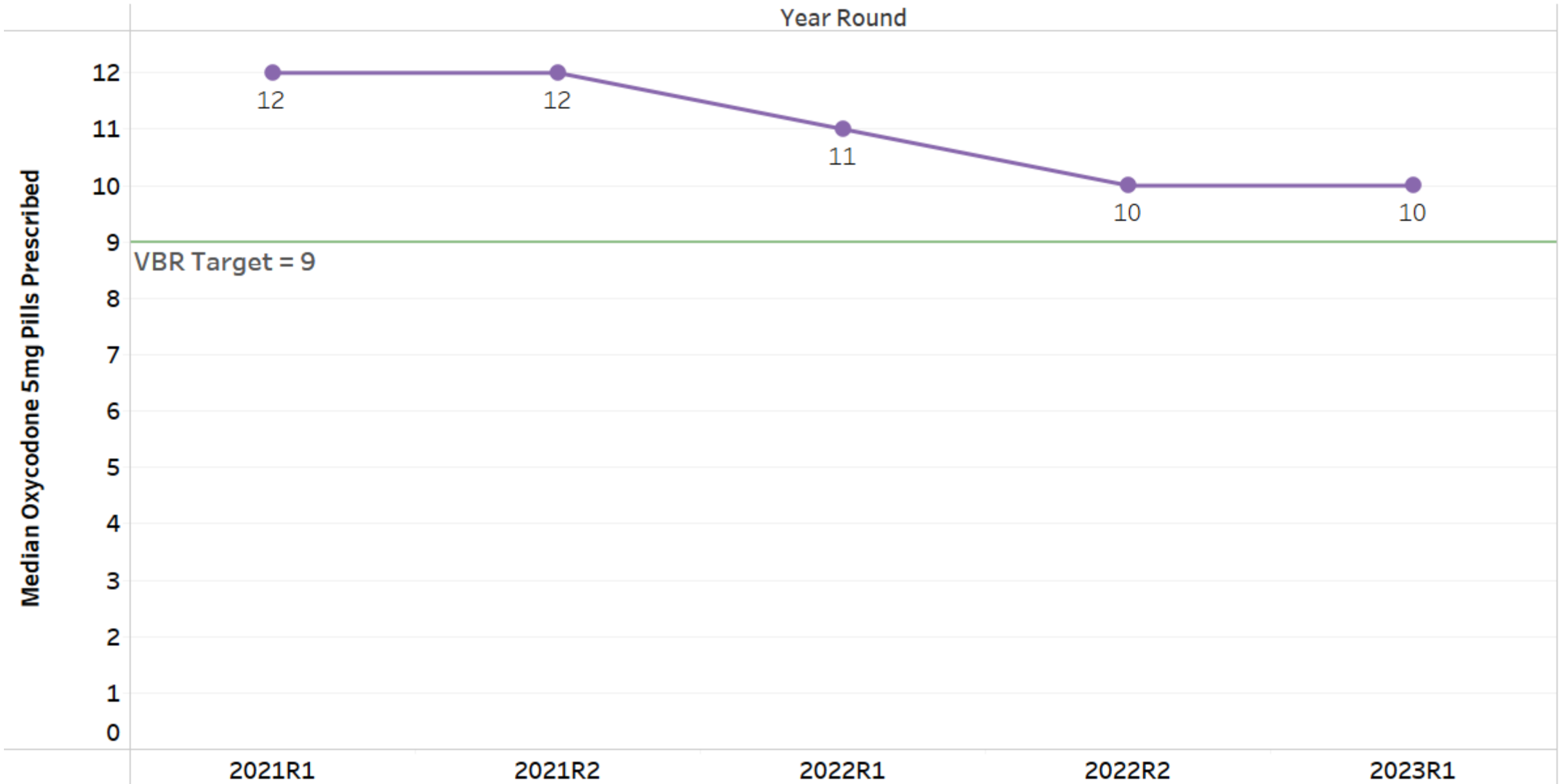
Morphine Equivalents (Lower Score - Better)
5/1/22 - 4/30/23



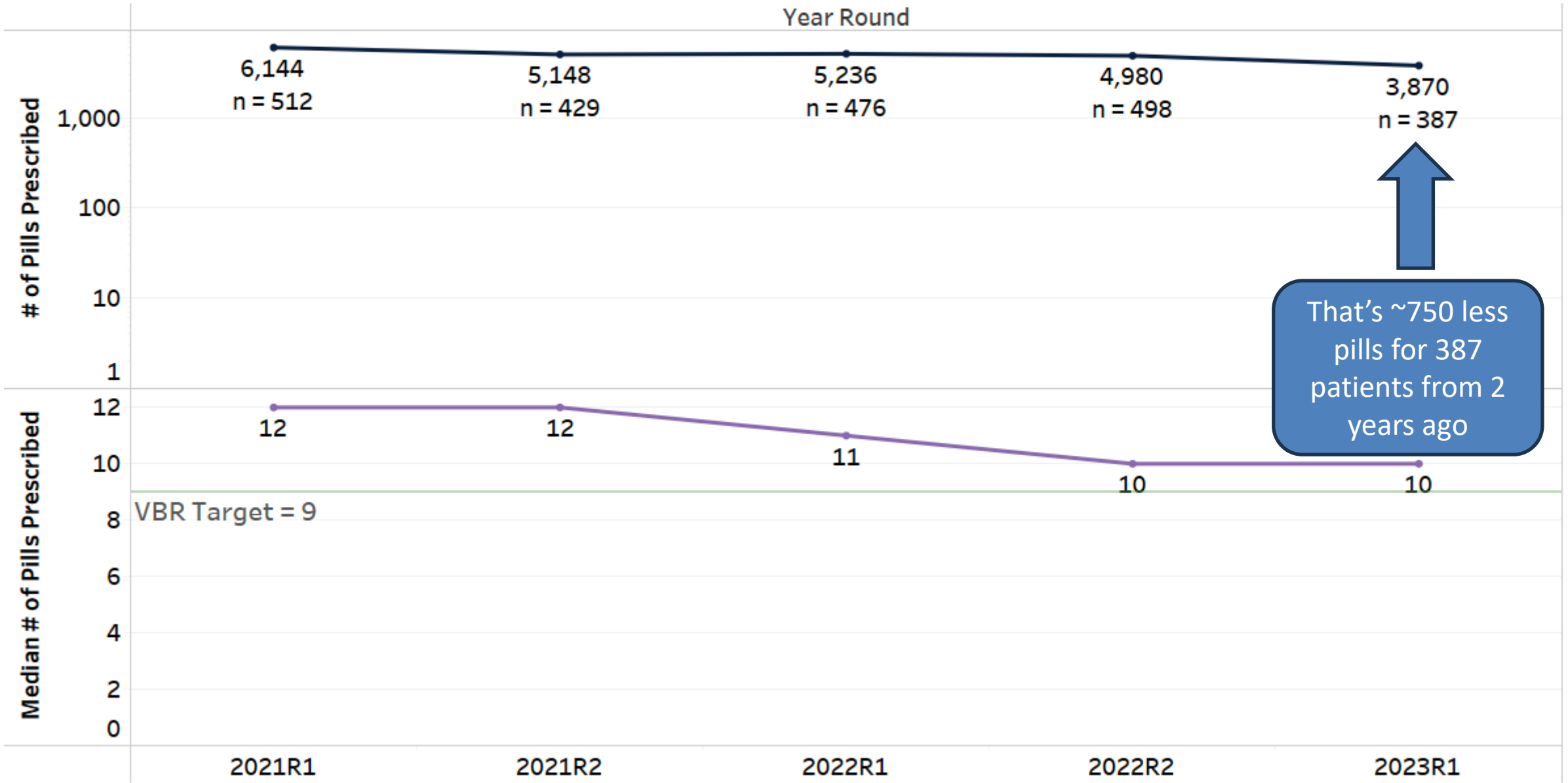
Oxycodone 5mg Pills (Lower Score - Better)
5/1/22 - 4/30/23



Median # of Oxycodone 5mg Pills (Lower Score - Better)
1/1/21 - 4/30/23



Median # of Pills Prescribed * # of Patients (Lower Score - Better)
1/1/21 - 4/30/23



Complete Family History Opportunity

2023 Fee Schedule Increase Summary

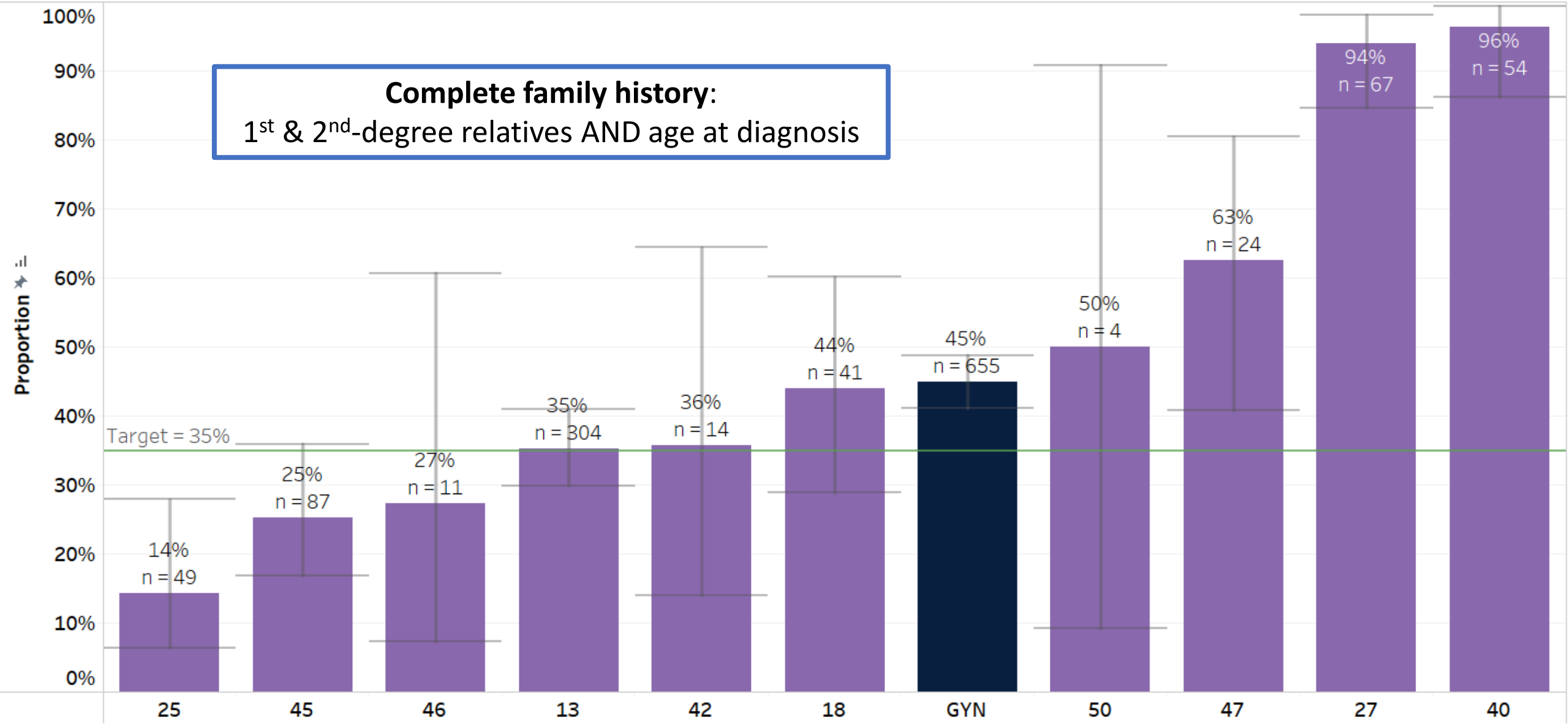
Tobacco Cessation Opportunity	
Collaborative-Wide (with Med Onc)	
Tobacco cessation counseling administered or patient referred in the past year	70%
2% Opportunity	

VBR Measure Opportunity	
Collaborative-Wide - Meet 2	
Days from debulking surgery to chemotherapy start	28 days
Outpatient prescribing of opioids for patients after laparoscopic or open hysterectomy	9 pills
3% Opportunity	

Complete Family History Opportunity	
Practice Meet Both	
Meet VBR measures	2
Complete family history documented for patients with invasive cancer	35%
Additional 2% Opportunity	

Total eligibility: up to 7%

108a: Complete Family History Document for Patients with Invasive Cancer
R2 2022 & R1 2023, n = 655



The State of Gynecologic Oncology In Michigan

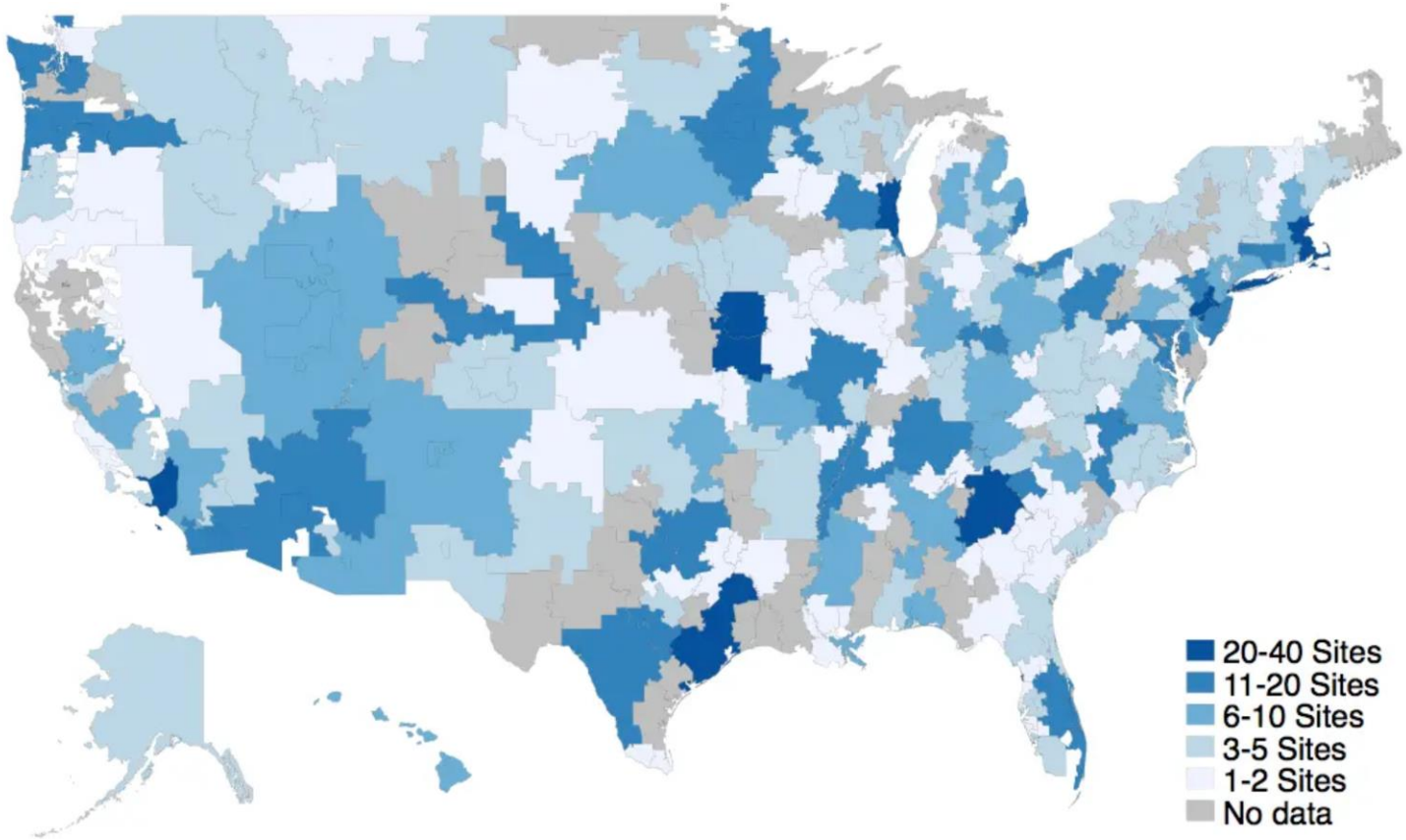
Bridget VandenBussche, CPHRM

Anna Hoekstra, MD, MPH

Shitanshu Uppal, MD, MBA

MOQC
MICHIGAN ONCOLOGY
QUALITY CONSORTIUM

Distribution of unique gynecologic oncology practice sites per hospital referral region in 2019



Source: Hicks-Courant et al., Gynecologic Oncology, 2021

The State of Gynecologic Oncology

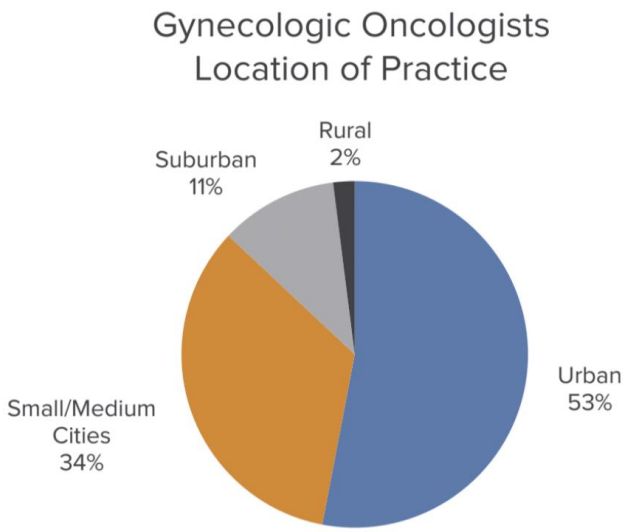
- 1178 gynecologic oncologists in 2020
- 95% of counties <1 provider in 2020 (54 million at-risk women)
- 7.8 million women with no provider within 100 miles of their county
- 1.09 gynecologic oncologists per 100,000 women in urban areas
- 0.1 gynecologic oncologist per 100,000 women (*P* <.01) in rural areas
- Accessibility to gynecologic oncologists in rural areas was similar in 2001-2005 (2.2%) and 2016-2020 (1.7%).

https://www.cancertherapyadvisor.com/home/news/conference-coverage/society-of-gynecologic-oncology-sgo/sgo-2023/54-million-women-us-may-lack-access-gynecologic-oncologist/

Desravines N, Desjardins M, Wethington S, Curriero F, Nickles Fader A. Geographic disparities in the U.S. gynecologic oncology workforce: Cancer care inequities and the paradox of more docs. SGO 2023. March 25-28, 2023.

The State of Gynecologic Oncology

US GO Gender within Region				
	Northeast	Midwest	South	West
Females	53%	62%	52%	60%
Males	47%	38%	48%	40%

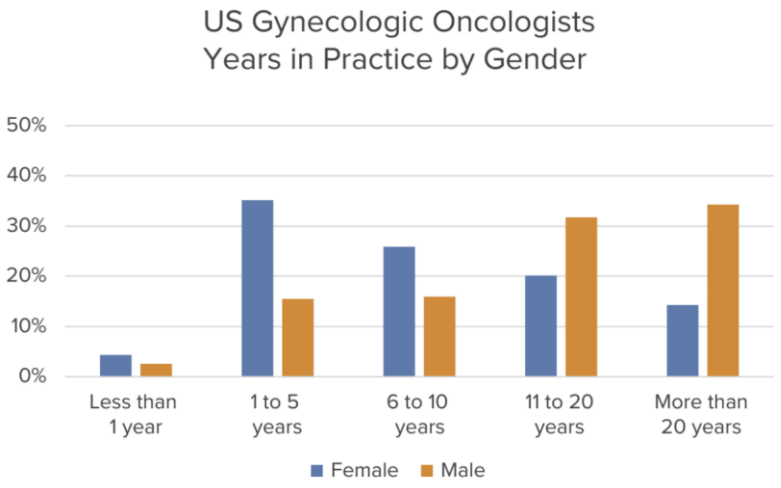


US GOs		
Private Practice	**2020**	**2015**
Owner - Solo practice	11%	18%
Partner - Single specialty partnership or group	17%	33%
Partner - Multi-specialty partnership or group	41%	37%
Employee or "junior partner" of a private practice	24%	12%
Other	7%	NA
Overall	21%	21%

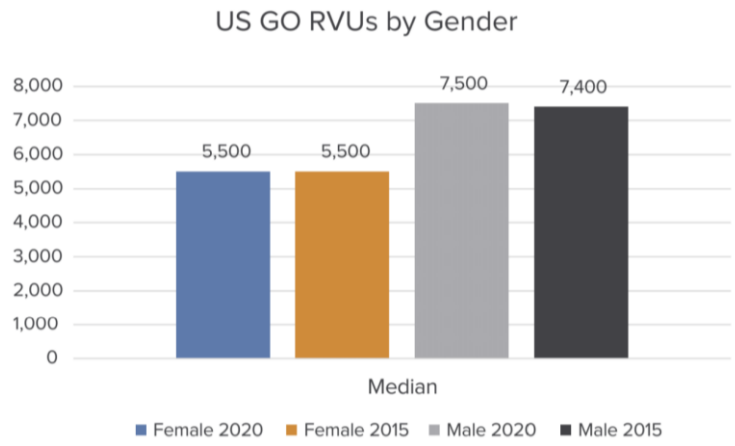
US GOs		
Non-Private Practice	**2020**	**2015**
University or medical school	73%	54%
Private hospital	14%	NA
Multispecialty clinic (with or without direct financial ties to a hospital)	9%	27%
HMO (whether or not the HMO also runs its own hospital)	2%	1%
Other	2%	0%
Federal government	1%	0%
State or local government	1%	0%

SGO Survey 2020

The State of Gynecologic Oncology



US GOs		
FTE – Mean Time	**2020**	**2015**
Clinical	63%	81%
Non-clinical	37%	19%

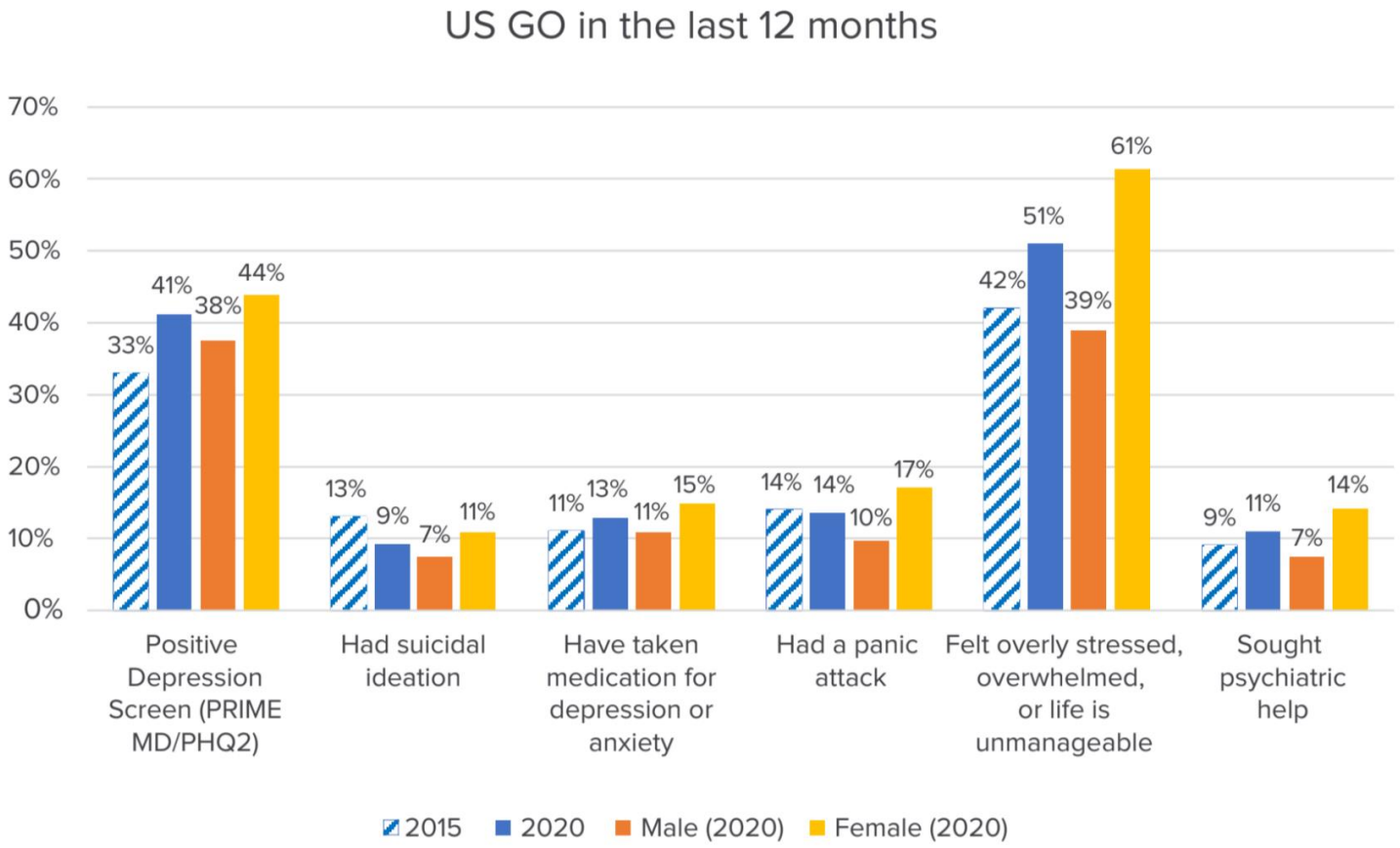


Surgical Volume Per Month		
	2020	2015
Benign Gynecology		
Mean	22	12
Median	8	7
Gynecologic Cancer		
Mean	30	26
Median	15	15
Assist Other Surgeons		
Mean	4	2
Median	2	1
On Standby		
Mean	2	1
Median	1	0
Obstetrical-related Cases		
Mean	1	NA
Median	1	NA

US GO Mean Base Salary by FTE				
% FTE	**Female**	**Median Age**	**Male**	**Median Age**
100%	$468,333	46	$423,400	43
99 - 85%	$404,227	44	$509,412	49
84 - 70%	$335,900	44	$436,385	51
69 - 50%	$331,273	46	$509,160	51
Less than 50%	$356,356	43	$494,249	51

SGO Survey 2020

The State of Gynecologic Oncology



SGO Survey 2020

The State of Gynecologic Oncology

Percentages of patients who did not have access to a gynecologic oncologist in 2016-2020:

- American Indian/Alaskan Native patients — 23.67%
- Hispanic patients — 9.46%
- White patients — 6.42%
- Black patients — 2.73%
- Asian/Pacific Islander patients — 1.36%

https://www.cancertherapyadvisor.com/home/news/conference-coverage/society-of-gynecologic-oncology-sgo/sgo-2023/54-million-women-us-may-lack-access-gynecologic-oncologist/

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Gynecologic Oncology in MOQC

2017 → 2021

Identified 18 practices = 34 surgeons

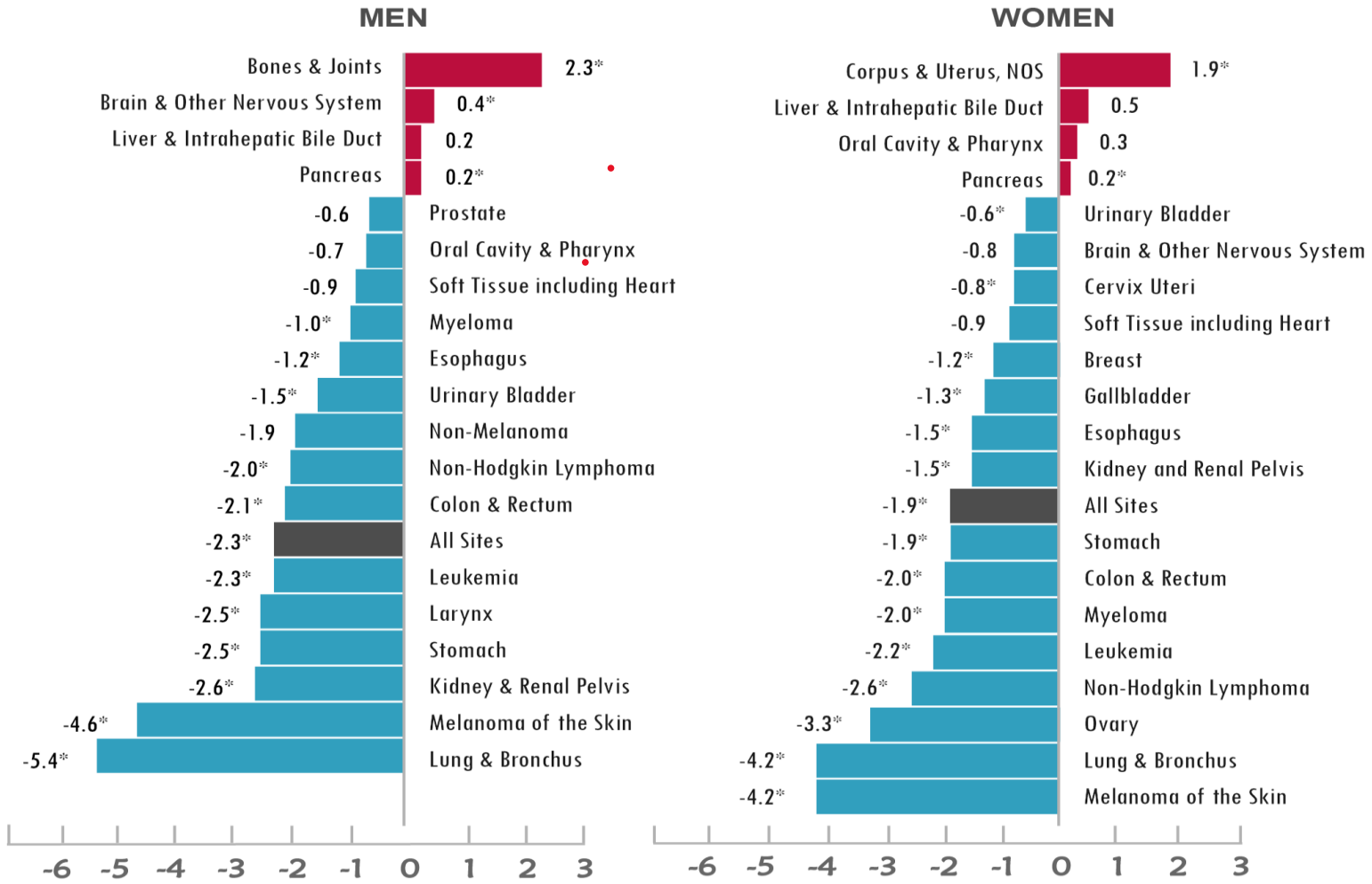
14 practices = 31 surgeons

2 practices to be recruited — 7 surgeons

TODAY

MOQC
MICHIGAN ONCOLOGY QUALITY CONSORTIUM

NATIONAL TRENDS IN CANCER DEATH RATES



AVERAGE ANNUAL PERCENT CHANGE (AAPC) 2015-2019

AAPC = average annual percent change

*AAPC is significantly different from zero ($p < .05$).

seer.cancer.gov

Source: Annual Report to the Nation

Number of Gynecology Oncology Physicians in Michigan

Year	Gyn Oncologists	Uterine Cancer	Cervix Cancer	Ovarian Cancer
2014	33	1851	343	740
2017	35	2029	344	633
2023	31	2420	310	610

https://gis.cdc.gov/Cancer/USCS/#/Trends/

Discussion

Small Group Discussions
2-3 Recommendations

- How can we build sustainable systems?
- Where can help be identified?
- What structural materials can be developed to support?

Lunch and Conversation

Afternoon Agenda

TIME	TOPIC	PRESENTER
12:45 pm	**28 Days to Chemotherapy – Is It Necessary And Is It Possible?**	Stefany Acosta-Torres, MD
1:15 pm	**Interprofessional Development: Expanding the Reach of MOQC**	Sharon Kim, MA Jennifer J. Griggs, MD, MPH
2:00 pm	**Break**	
2:05 pm	**MIOCA Update**	Megan Neubauer, AM
2:35 pm	**MOQCLink Dashboards**	Keli DeVries, LMSW Vanessa Aron, BA
3:05 pm	**MOQC Updates**	Jennifer Griggs, MD, MPH
3:20 pm	**Closing Remarks**	Vanessa Aron, BA

28 Days to Chemotherapy
Is It Necessary And Is It Possible?

Stefany Acosta-Torres, MD

MOQC
MICHIGAN ONCOLOGY
QUALITY CONSORTIUM

Why should we minimize time between surgery and chemotherapy?

- Residual disease following cytoreductive surgery may have a high growth fraction making it more susceptible to chemotherapy
- However, extended interval between surgery and chemotherapy may provide an opportunity for micrometastases to proliferate, rendering it less susceptible to chemotherapy

How did we come to 28 days?

- In a secondary analysis of GOG 218, Tewari et al (2016) demonstrated that chemotherapy delayed beyond 21-35 days in 81 women with stage IV ovarian cancer who underwent PDS to NGR is associated with decreased survival
- Seagle et al (2017) used NCDB to demonstrate that in 45,000 women with ovarian cancer, chemotherapy delay > 35 days from surgery was associated with a 7% increased hazard of death
  - Relative hazard of death was lowest between 25 and 29 days after surgery BUT was not significantly different within the longer two-week interval from 21 to 35 days

GOG218 – Deep Dive

- GOG 218 – phase III RCT designed to determine whether the incorporation of bevacizumab to chemotherapy, and in the maintenance setting, improves PFS in women with stage III-IV ovarian cancer
- Median time from surgery to initiation of chemotherapy was 31 days in each arm
- Initiation of therapy after 25 days was associated with increased risk of death
- The microscopic residual group was most affected by lengthening time from surgery to initiation of chemotherapy

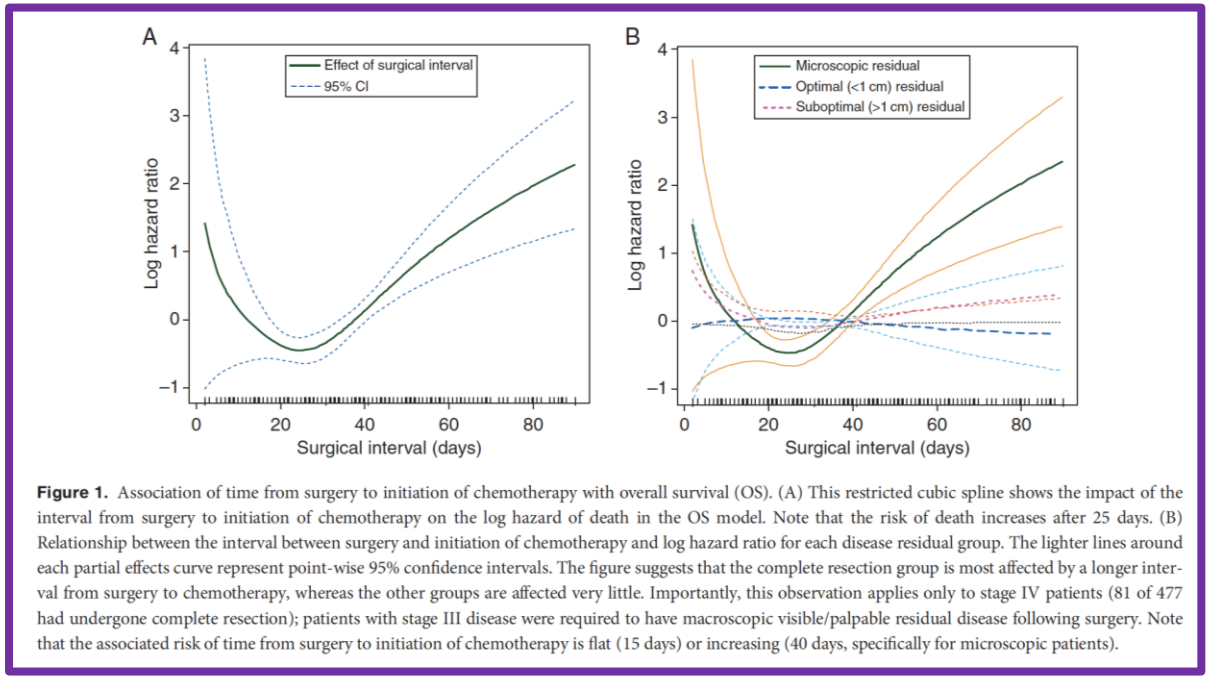
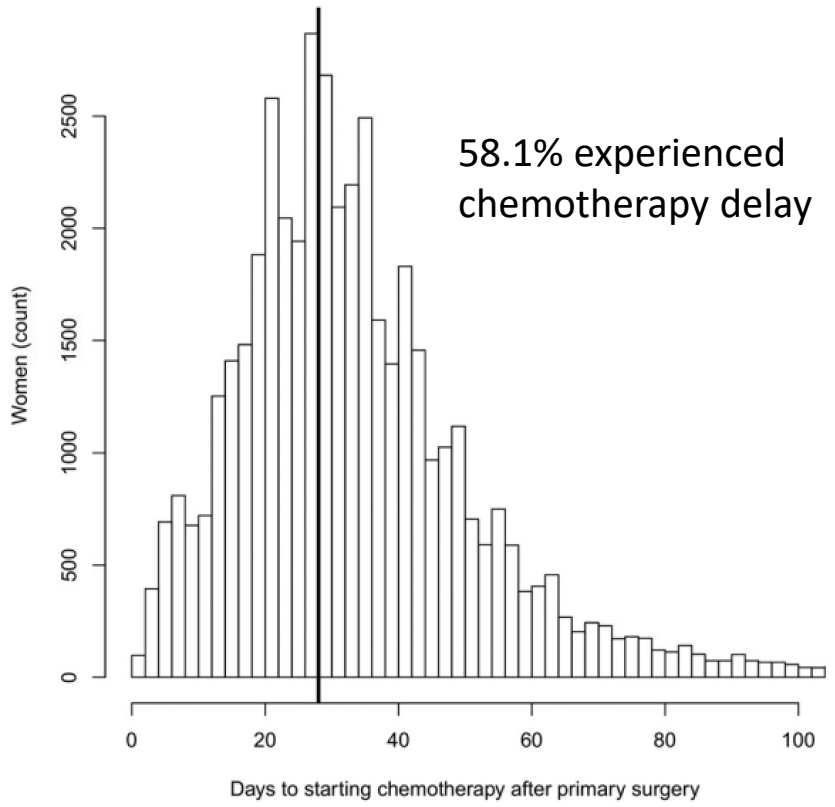


Figure 1. Association of time from surgery to initiation of chemotherapy with overall survival (OS). (A) This restricted cubic spline shows the impact of the interval from surgery to initiation of chemotherapy on the log hazard of death in the OS model. Note that the risk of death increases after 25 days. (B) Relationship between the interval between surgery and initiation of chemotherapy and log hazard ratio for each disease residual group. The lighter lines around each partial effects curve represent point-wise 95% confidence intervals. The figure suggests that the complete resection group is most affected by a longer interval from surgery to chemotherapy, whereas the other groups are affected very little. Importantly, this observation applies only to stage IV patients (81 of 477 had undergone complete resection); patients with stage III disease were required to have macroscopic visible/palpable residual disease following surgery. Note that the associated risk of time from surgery to initiation of chemotherapy is flat (15 days) or increasing (40 days, specifically for microscopic patients).

Seagle, et al – Deep Dive

Median = 31 days



58.1% experienced chemotherapy delay

Fig. 1. Histogram of days to chemotherapy initiation after primary debulking surgery. Vertical line is 28 days.

Table 3
Hazards of death from multivariable Cox regression of time to chemotherapy initiation.

$n = 15{,}752$; deaths = 9,315	HR (95% CI), *P*
Time to chemotherapy initiation (days)	
<21	1.13 (1.07–1.20), 2.1 e-5
21–28	1 (reference)
29–35	0.99 (0.93–1.07), 0.964
36–49	1.09 (1.02–1.16), 0.008
≥50	1.07 (1.00–1.15), 0.061
Comorbidity score	
0	1 (reference)
1	1.12 (1.06–1.19), 1.5 e-4
2	1.37 (1.21–1.56), 1.0 e-6
Insurance status	
Uninsured	1 (reference)
Private	0.96 (0.86–1.08), 0.494
Medicaid	1.25 (1.08–1.45), 0.003
Medicare	1.20 (1.06–1.36), 0.003
Government	0.94 (0.72–1.23), 0.663
Unknown	1.02 (0.85–1.22), 0.836
Race & Community median income quartile ($)	
White: <30.000	1 (reference)
White: 30,000–34,999	1.01 (0.93–1.11), 0.760
White: 35,000–45,999	1.03 (0.95–1.11), 0.502
White: ≥46,000	0.95 (0.88–1.03), 0.228
Black: <30.000	1.49 (1.29–1.72), 8.4 e-8
Black: 30,000–34,999	0.87 (0.68–1.11), 0.250
Black: 35,000–45,999	0.71 (0.57–0.89), 0.003
Black: ≥46,000	0.74 (0.58–0.94), 0.012
Other: <30.000	0.62 (0.40–0.95), 0.028
Other: 30,000–34,999	1.80 (1.01–3.21), 0.048
Other: 35,000–45,999	1.43 (0.86–2.38), 0.167
Other: ≥46,000	1.61 (1.01–2.56), 0.044
Unknown: <30.000	0.99 (0.55–1.81), 0.979
Unknown: 30,000–34,999	0.68 (0.30–1.57), 0.369
Unknown: 35,000–45,999	1.18 (0.59–2.33), 0.645
Unknown: ≥46,000	0.89 (0.46–1.74), 0.740
Stratification variables	Age categories, stage, grade, histology
Model *P*	<2.0 e-16

HR (95% CI), *P*: Hazard ratio (95% confidence interval), *p*-value.

Covariate-adjusted HR for death demonstrate that women who began chemotherapy 21-35 days after PDS experienced decreased HR for death compared to women who began ≥ 36 days or <21 days after PDS

Comparing results between both studies

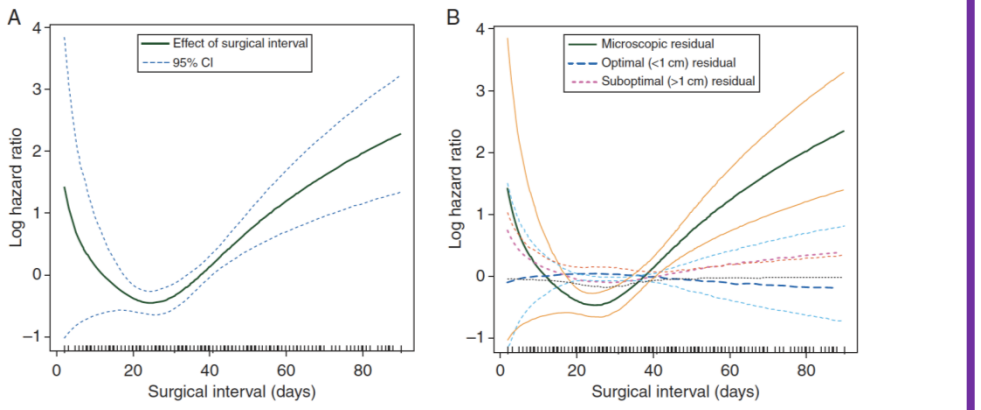


Figure 1. Association of time from surgery to initiation of chemotherapy with overall survival (OS). (A) This restricted cubic spline shows the impact of the interval from surgery to initiation of chemotherapy on the log hazard of death in the OS model. Note that the risk of death increases after 25 days. (B) Relationship between the interval between surgery and initiation of chemotherapy and log hazard ratio for each disease residual group. The lighter lines around each partial effects curve represent point-wise 95% confidence intervals. The figure suggests that the complete resection group is most affected by a longer interval from surgery to chemotherapy, whereas the other groups are affected very little. Importantly, this observation applies only to stage IV patients (81 of 477 had undergone complete resection); patients with stage III disease were required to have macroscopic visible/palpable residual disease following surgery. Note that the associated risk of time from surgery to initiation of chemotherapy is flat (15 days) or increasing (40 days, specifically for microscopic patients).

Tewari et al

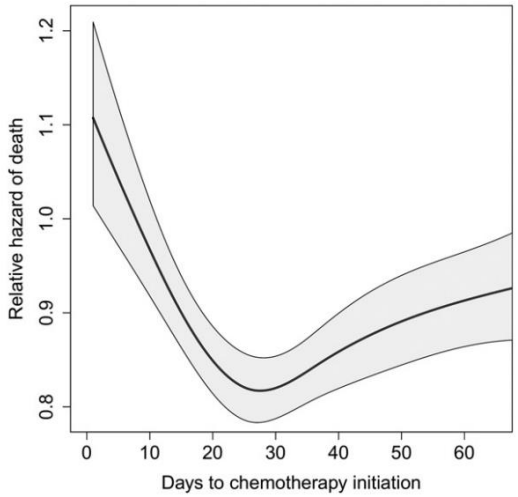
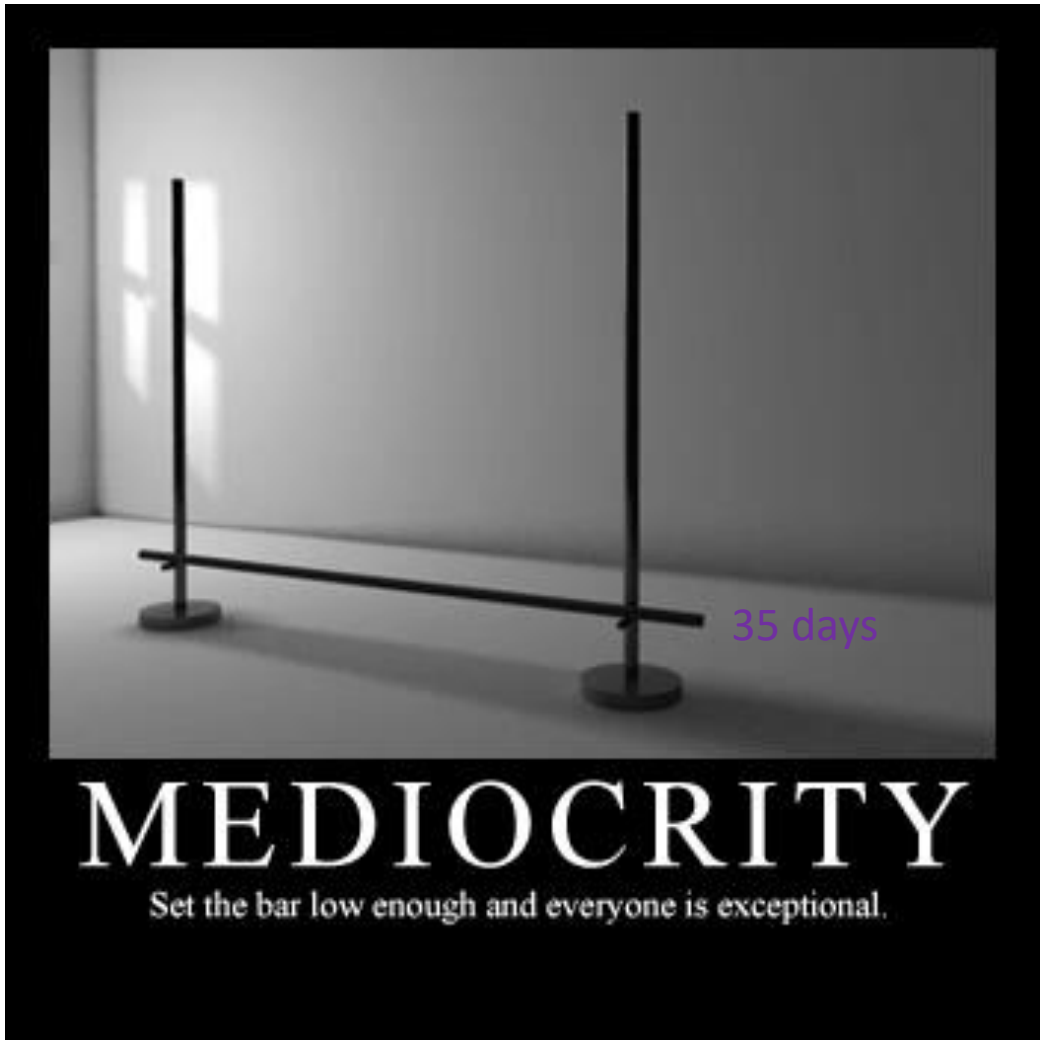


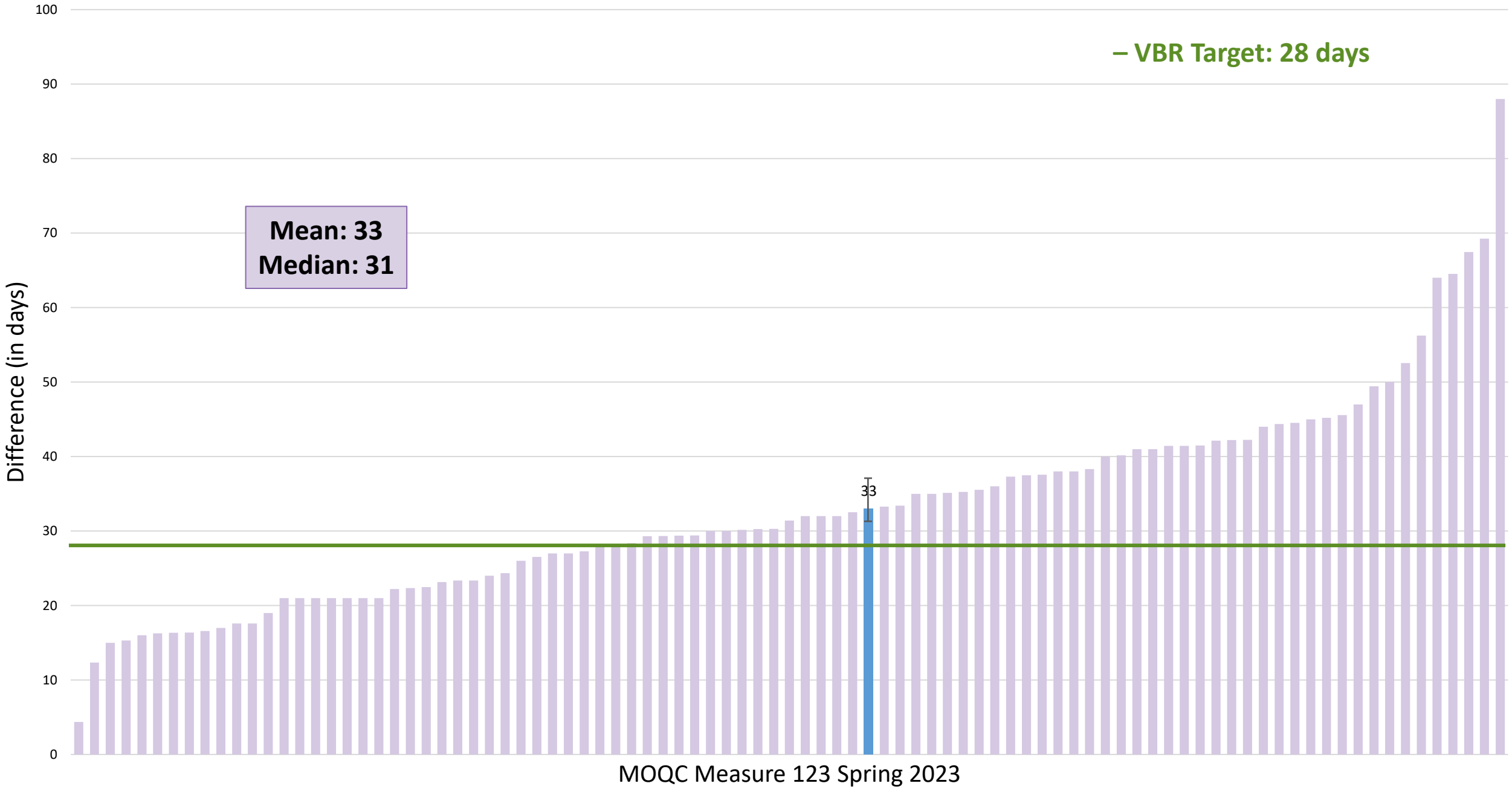
Fig. 2. Relative hazard of death as a function of days to chemotherapy initiation. Shaded area is the point-wise 95% confidence interval of the relative hazard estimates.

Seagle et al

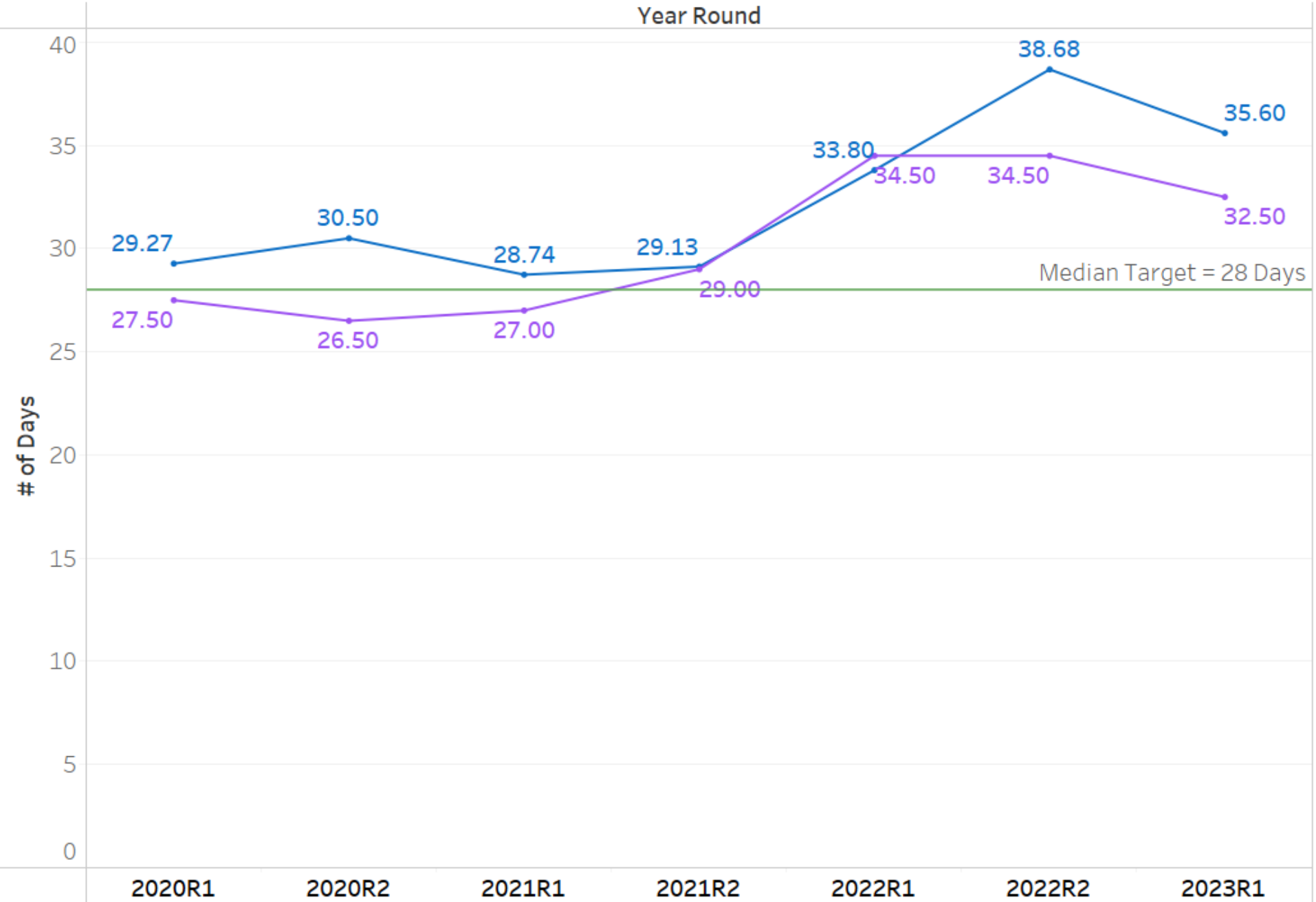
Reconsidering the desirable window for chemotherapy initiation: 21-35 days



Median of MOQC-participating sites is 31 days, but there is significant variability



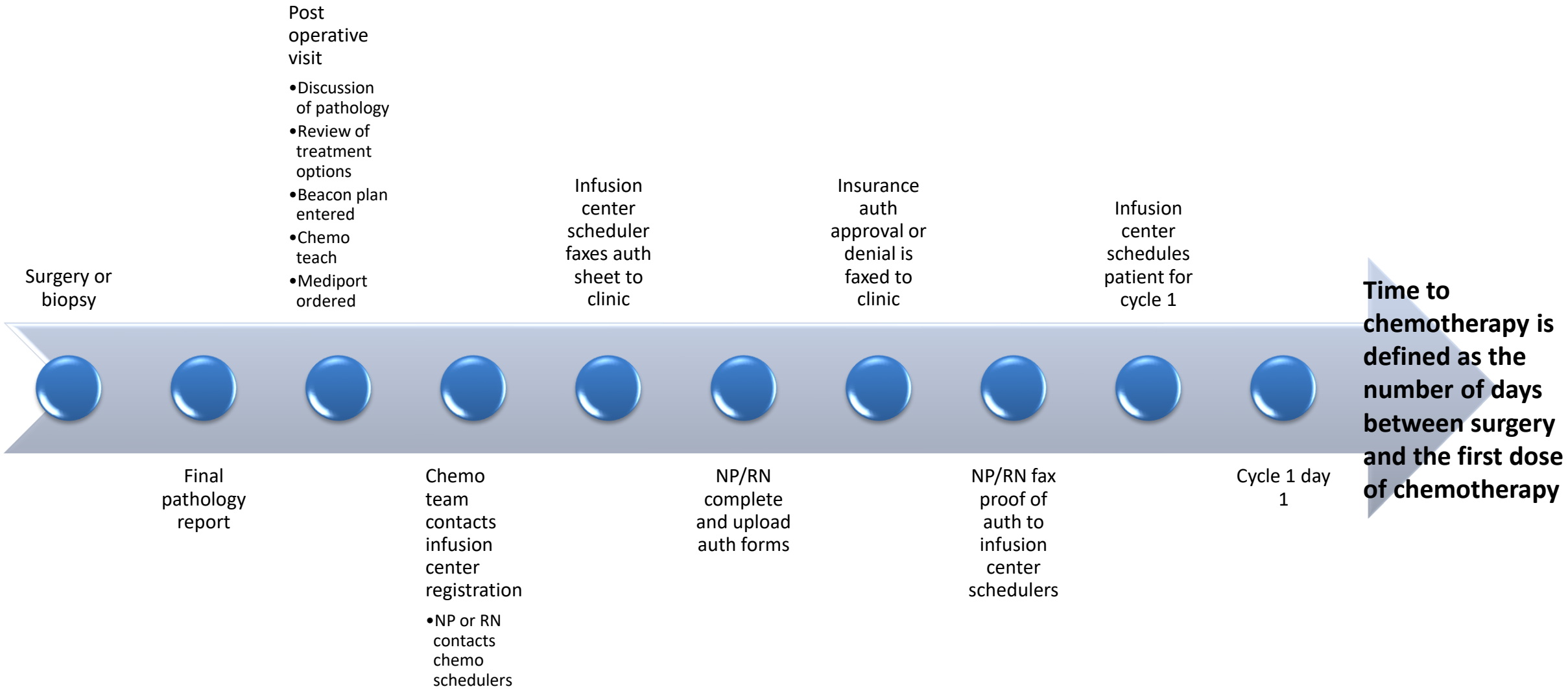
Days From Debulking Surgery to Chemo Start



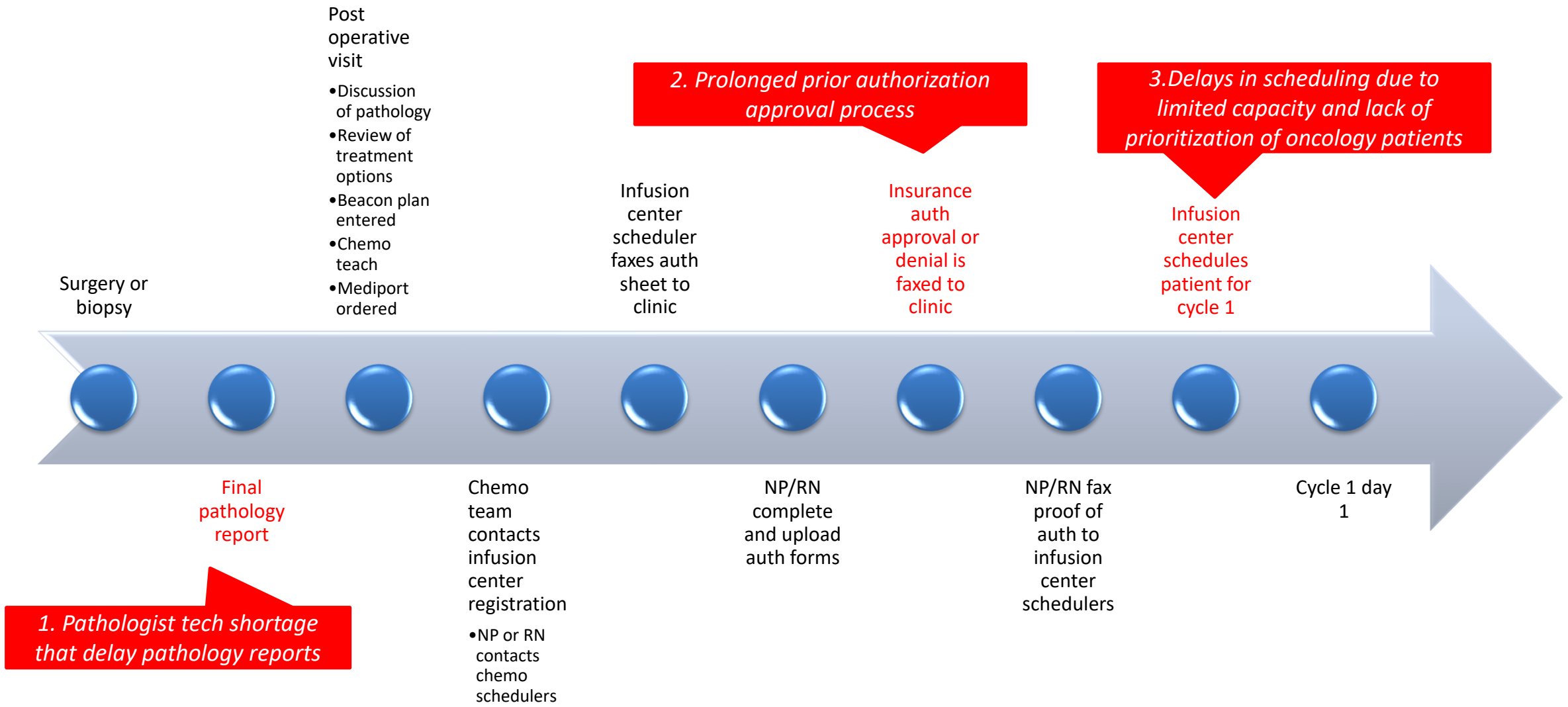
Measure Names

- Mean Surgery to ChemoStart Days
- Median Surgery to ChemoStart Days

The Corewell East road from surgery/biopsy to chemotherapy



We identified 3 hypotheses that could explain delays



To evaluate our hypotheses, had staff log the duration of each step

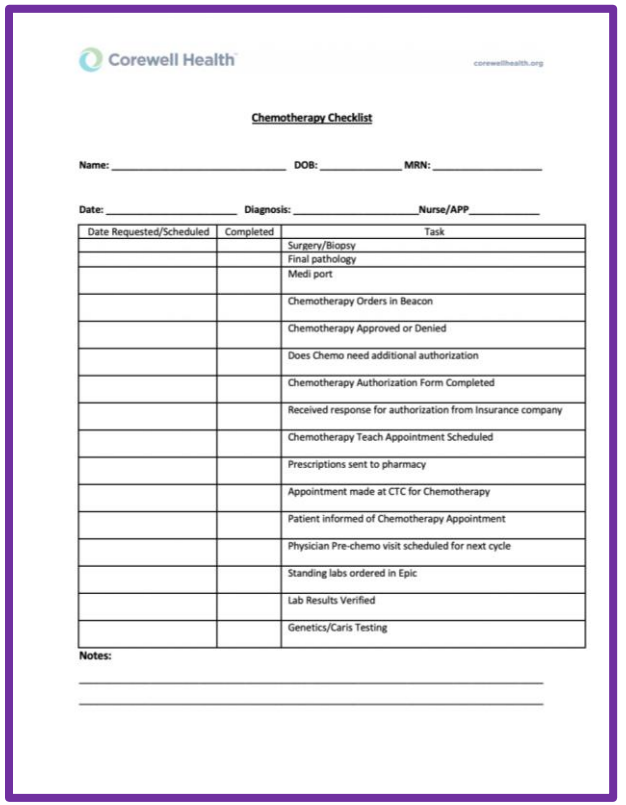
Inclusion Criteria

- Neoadjuvant or adjuvant chemotherapy administered by Corewell East Gyn Onc
- Staging or primary/interval cytoreductive surgery performed by Corewell East Gyn Onc
- Confirmation of histology if biopsy prior to NACT performed at outside institution
- Recurrent cancer with > 1 year since last systemic treatment

Exclusion Criteria

- Did not receive surgery AND chemotherapy at Corewell Health East Gynecologic Oncology practice
- Clinical trial participant
- Locally advanced cervical cancer receiving platinum agent with radiation
- Unable to receive carboplatin or cisplatin during chemotherapy shortage
- Recurrent cancer with < 1 year since last systemic treatment

Form



Corewell Health

corewellhealth.org

Chemotherapy Checklist

Name: _____ **DOB:** _____ **MRN:** _____

Date: _____ **Diagnosis:** _____ **Nurse/APP**_____

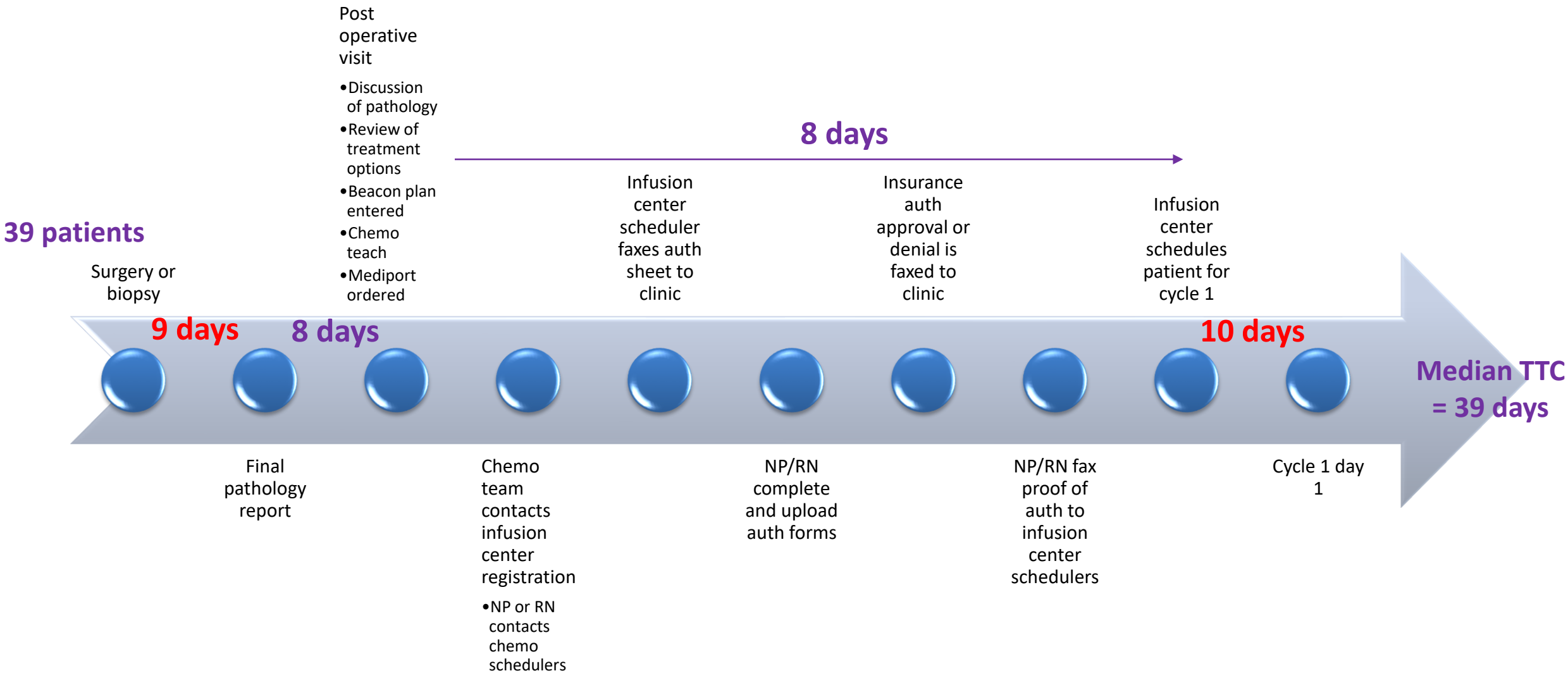
Date Requested/Scheduled	Completed	Task
		Surgery/Biopsy
		Final pathology
		Medi port
		Chemotherapy Orders in Beacon
		Chemotherapy Approved or Denied
		Does Chemo need additional authorization
		Chemotherapy Authorization Form Completed
		Received response for authorization from Insurance company
		Chemotherapy Teach Appointment Scheduled
		Prescriptions sent to pharmacy
		Appointment made at CTC for Chemotherapy
		Patient informed of Chemotherapy Appointment
		Physician Pre-chemo visit scheduled for next cycle
		Standing labs ordered in Epic
		Lab Results Verified
		Genetics/Caris Testing

Notes:

_____

_____

We found that our median time to chemo was 39 days, with significant delays in scheduling patients after approval



Evaluated 4 outliers, finding that most negative outliers outside the clinic's control

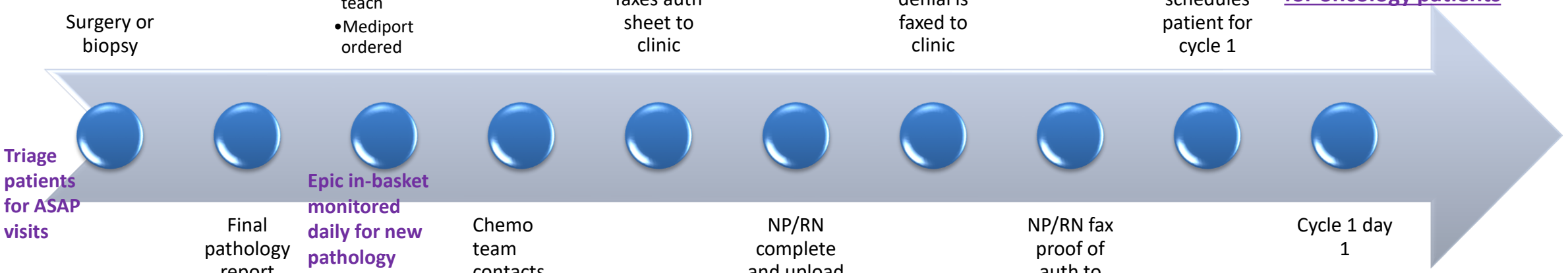
Patient	TTC	Clinical Summary	Barrier to care
PL	127 days	76yo with MMRd recurrent endometrioid adenocarcinoma following FIGO grade 1 stage IB EC s/p RA-TLH/BSO/SLNB and brachytherapy 2 years prior.	*Plan for EBRT to left psoas mass followed by pembrolizumab. RT completed 85 days following biopsy *MMR IHC unsuccessful. CARIS results demonstrating MMRd obtained 91 days following biopsy *Cycle 1 scheduled 85 days after inputting Pembrolizumab in EMR secondary to **prolonged PA delayed by lack of MMR results**
BS	85 days	54 yo with newly diagnosed high grade serous ovarian cancer with plan for NACT	*Scheduled with GYO 25 days after biopsy obtained. *Required colonoscopy followed by **diverting colostomy secondary to tumor invading completely into rectum.** Performed 56 days following biopsy (31 days after initial GYO visit). *1 week prior to C1D1 underwent imaging **demonstrating 2.5cm breast mass**. Request from GYO provider to infusion clinic for 1 week delay to allow for biopsy and path review. Infusion center rescheduled with 2-week delay.
SW	72 days	73 yo with Stage IIIC1 carcinosarcoma or the uterus s/p surgical staging	*Final pathology report released 13 days after surgery *Insurance approval obtained 20 days following provider request *Cycle 1 scheduled 32 days following insurance approval due to **death of the patient's husband**
FA	14 days	69 yo with MMRd recurrent endometrioid adenocarcinoma following FIGO grade 2 stage IA EC s/p RA-TLH/BSO/SLNB 1 year prior	*Pathology report released 3 days following biopsy *Treatment plan inputted EMR 1 day following pathology report *No PA required *Chemotherapy scheduled 4 days after request made by clinic

These social determinants of outliers is consistent with prior literature

- Seagle et al demonstrated that minority representation, older age, increased comorbidities, low socioeconomic status, public insurance, and care at a community cancer center were associated with a chemotherapy delay

The Corewell East road from surgery/biopsy to chemotherapy: How can we improve?

Minimize hand off by creating workflow in which infusion schedulers OR clinic staff have capabilities to determine, complete, and submit PA



Place mediport at time of surgery

Surgery or biopsy

Post operative visit
- Discussion of pathology
- Review of treatment options
- Beacon plan entered
- Chemo teach
- Mediport ordered

Infusion center scheduler faxes auth sheet to clinic

Insurance auth approval or denial is faxed to clinic

Infusion center schedules patient for cycle 1

Reserve infusion chairs for oncology patients

Triage patients for ASAP visits

Final pathology report

Epic in-basket monitored daily for new pathology reports

Chemo team contacts infusion center registration
- NP or RN contacts chemo schedulers

NP/RN complete and upload auth forms

NP/RN fax proof of auth to infusion center schedulers

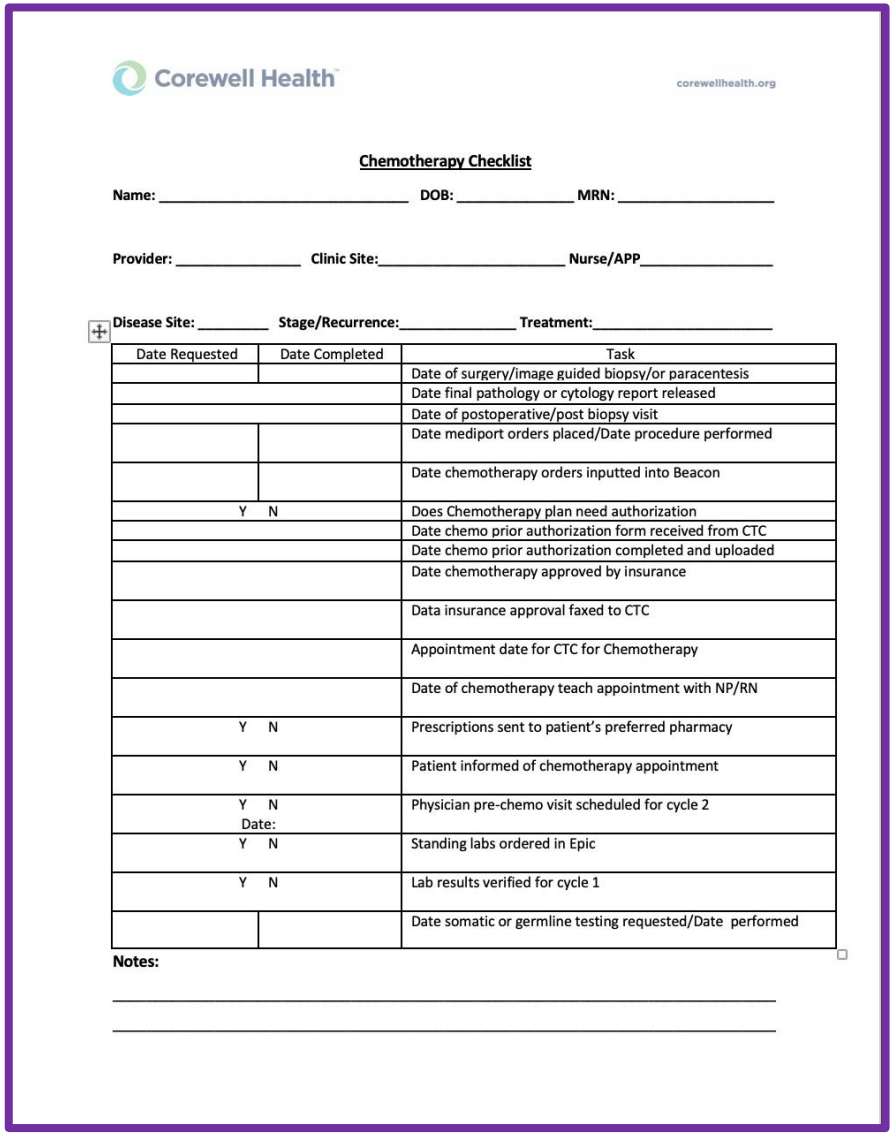
Cycle 1 day 1

1. **Outsource pathology**
2. **Use frozen section to create preliminary treatment plan and obtain PA**

Automatic prior authorizations – decreasing the time between when a provider prescribes a treatment and receives confirmation from the patient's payer regarding whether the procedure will be covered

- Humana and Epic partnered to create electronic prior authorization (ePA) using the Real-Time Benefits Check tool
- Electronic prior authorizations have the potential to speed up care delivery
- In pilot study, a third of prior authorizations took two hours or less to complete

Improving data collection



Corewell Health

corewellhealth.org

Chemotherapy Checklist

Name: _____ **DOB:** _____ **MRN:** _____

Provider: _____ **Clinic Site:**_____ **Nurse/APP**_____

Disease Site: _____ **Stage/Recurrence:**_____ **Treatment:**_____

Date Requested	Date Completed	Task
		Date of surgery/image guided biopsy/or paracentesis
		Date final pathology or cytology report released
		Date of postoperative/post biopsy visit
		Date mediport orders placed/Date procedure performed
		Date chemotherapy orders inputted into Beacon
Y N		Does Chemotherapy plan need authorization
		Date chemo prior authorization form received from CTC
		Date chemo prior authorization completed and uploaded
		Date chemotherapy approved by insurance
		Data insurance approval faxed to CTC
		Appointment date for CTC for Chemotherapy
		Date of chemotherapy teach appointment with NP/RN
Y N		Prescriptions sent to patient's preferred pharmacy
Y N		Patient informed of chemotherapy appointment
Y N Date:		Physician pre-chemo visit scheduled for cycle 2
Y N		Standing labs ordered in Epic
Y N		Lab results verified for cycle 1
		Date somatic or germline testing requested/Date performed

Notes:

_____

_____

Questions?

Interprofessional Development: Expanding the Reach of MOQC

Sharon Kim, POQC

Jennifer Griggs, MD, MPH

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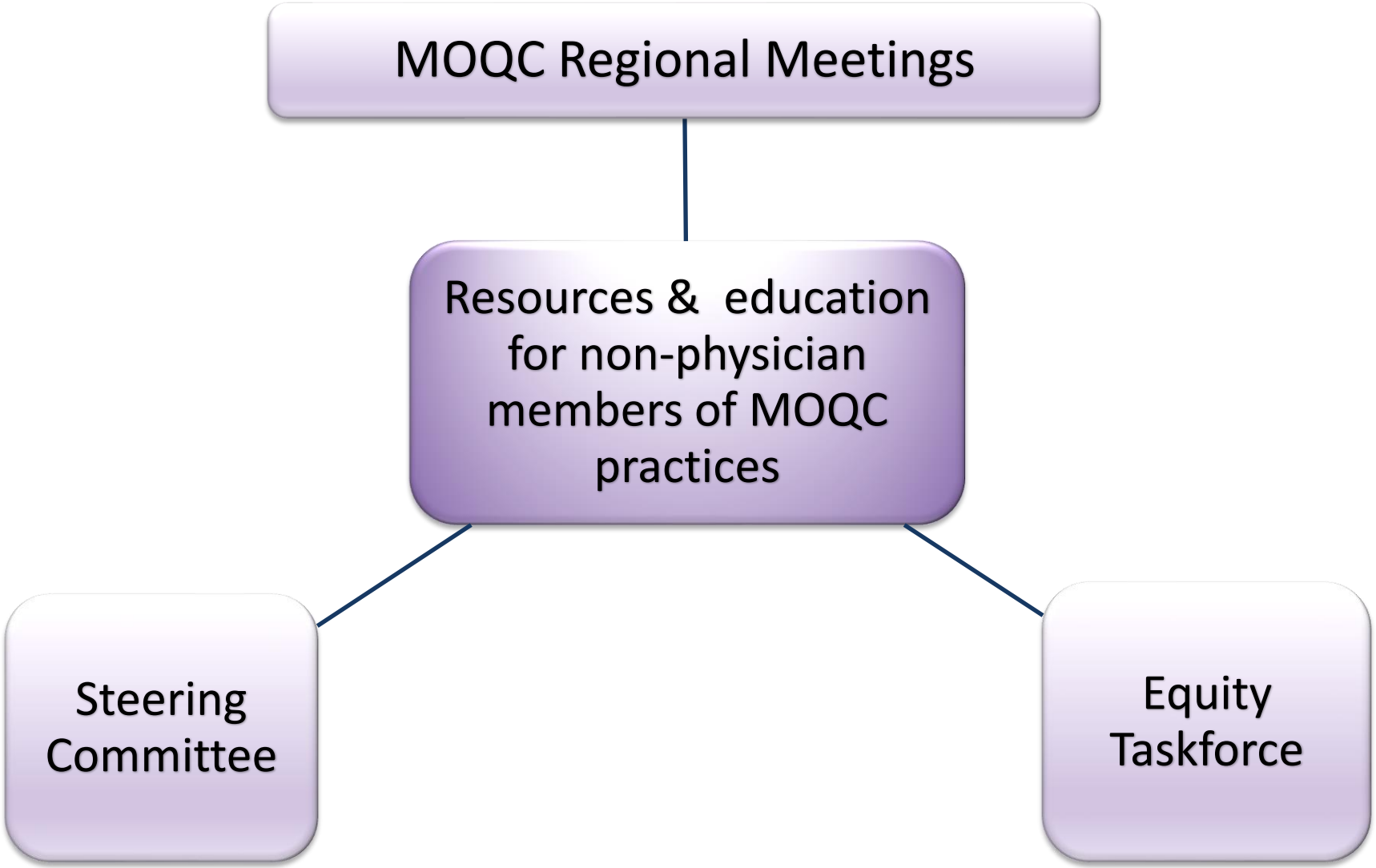
Introduction



What would it make possible?

The “Why”

- Fills a need for education across team members
- Taps into the expertise of multiple team members
- Creates an understanding of quality improvement
- Provides a better understanding of the needs of patients and families
- Increases engagement, fulfillment, and satisfaction of staff
- Gives more people the opportunity to contribute to the work of MOQC

What else would it make possible?

The “Why”

- May decrease staff turnover
- May improve relationships & increase collaboration in practices
- May improve the patient & caregiver experience
- May enhance alignment of team members around goals of care and purpose of treatment

Request for today

The “What”

Brainstorming about

- what opportunities we can offer
- to whom

Development Example

VitalTalk Application

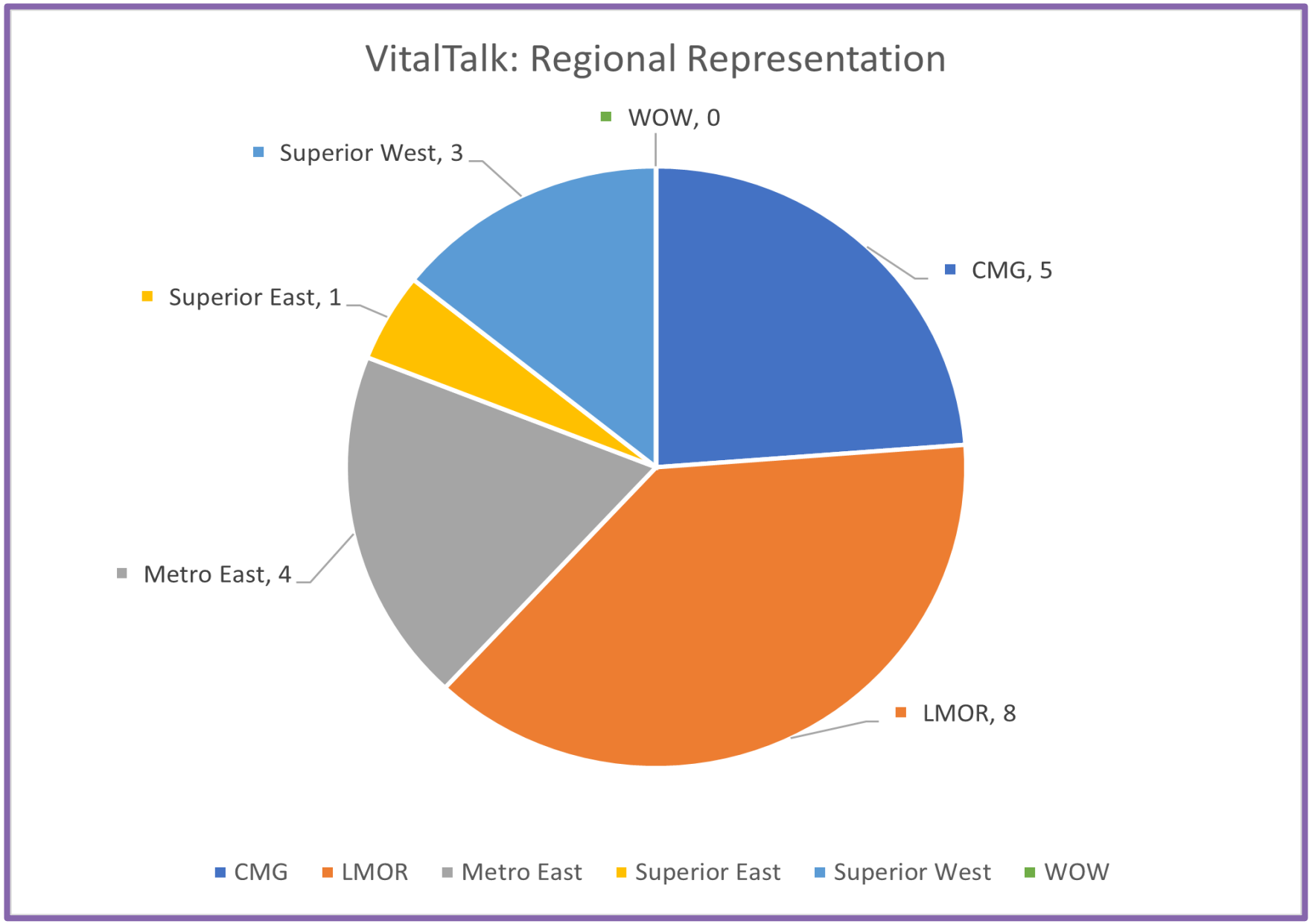
VitalTalk introduced during June biannual meeting

Two training options offered:
- Navigating Serious Conversations/NSC (3 modules, videos, self-paced)
- Mastering Tough Conversations/MTC (scheduled, two four-hour sessions, live virtual instruction)

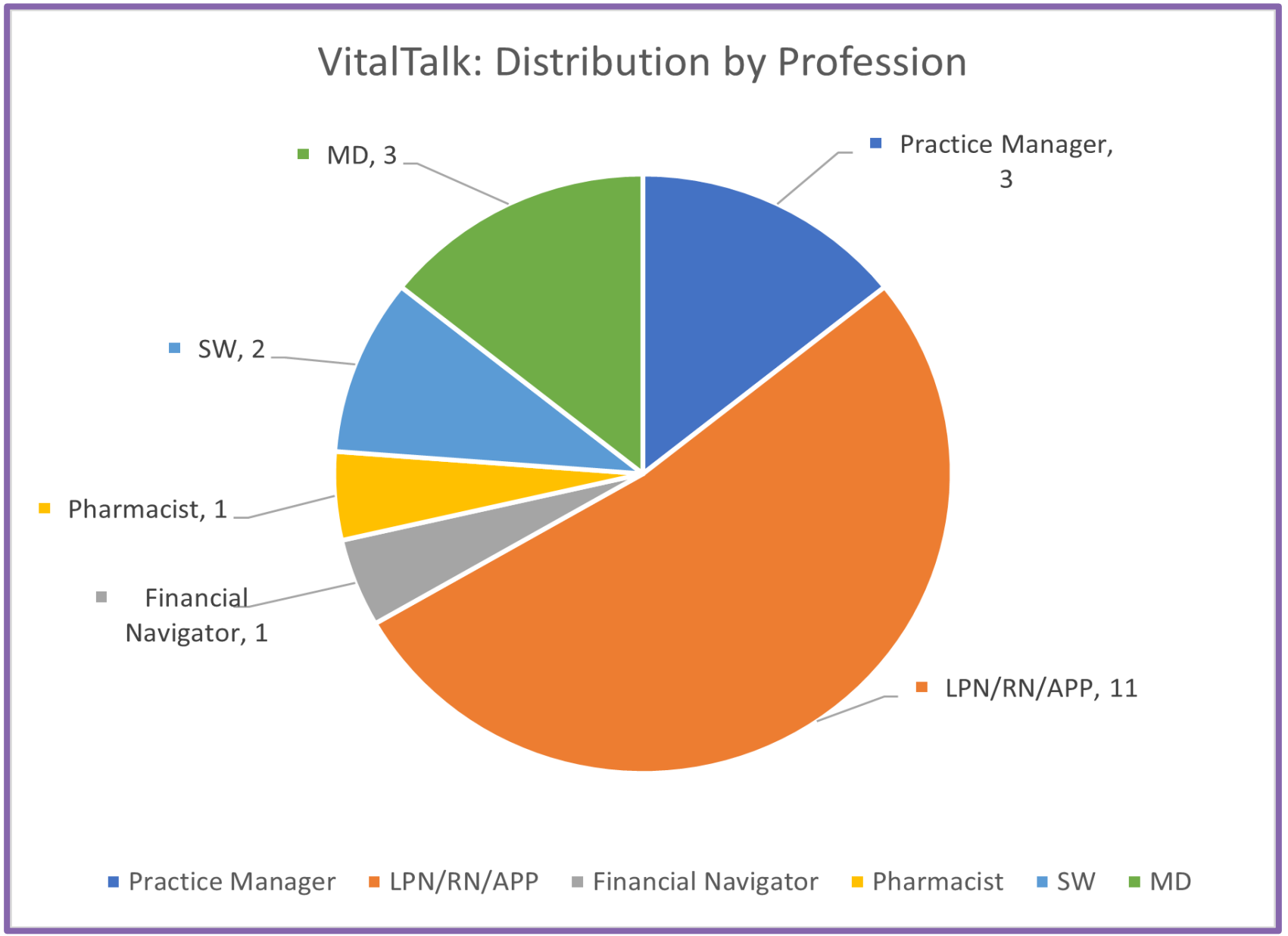
Application open June 26 – July 21, 2023

21 total (complete) applications received:
- 11 NSC
- 10 MTC

VitalTalk Application



VitalTalk Application

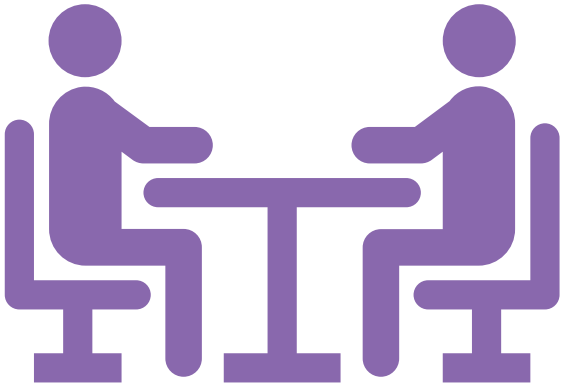


VitalTalk Application

Next steps:

- Follow up with unregistered participants – continuous
- Reach out upon completion – timeline varies
- Collect testimonials – by Feb 29, 2024
- Communicate to BCBSM
- Share with practices

Discussion



- What roles could be included in IPD?
- What topics could be covered?
- What could go wrong?

Implementation Interest

https://umich.qualtrics.com/jfe/form/SV_cw3SfcijlEZQRaC

Break

MIOCA Updates

Megan Neubauer, AM

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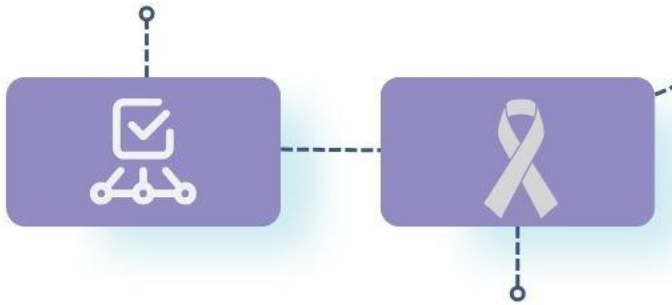
MIOCA and MOQC Partnership Updates

October 2023

MIOCA & MOQC
SERVING THE OVARIAN CANCER COMMUNITY

MIOCA

Providing resources, connections and support for Michigan patients and their families.

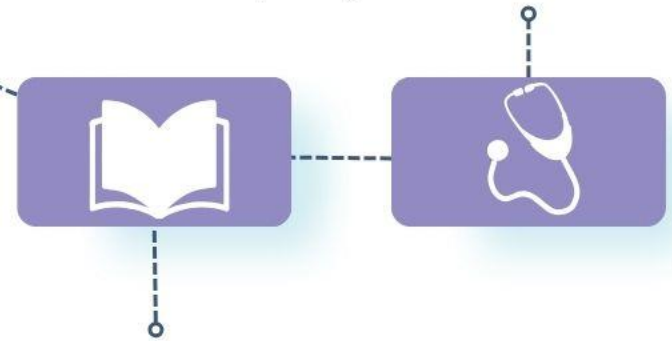


Working to increase awareness and collaborate to ensure positive movement in the field.

Together serving patients and providers to work toward better outcomes for Michiganders with ovarian cancer.

MOQC

Serving providers across the state to increase the quality of care.



Creating resources to support patients throughout treatment and survivorship.

MIOCA PROVIDES

SUPPORT

Those diagnosed ovarian cancer as well as their friends, family members and caregivers

PROGRAMING & EVENTS

To educate and connect those affected by ovarian cancer and raise awareness statewide

RESEARCH

By investing in Michigan's scientific community focused on innovative ovarian cancer studies

Patient and Caregiver Support

- Monthly Caregiver Group
- General Survivor Groups
- Younger Survivor Group
- Welcoming New Members Throughout the Year
- Open to Collaboration and Connection of Groups

Upcoming Highlights

Clinical Trials

FACCTS -Facts About Cancer Clinical Trials Program with Karmanos

October 16, 6:00 pm at Gilda's Club @ Durfee and available virtually

Research

Ovarian Cancer Research Symposium

October 10 at Wayne State University, virtual registration still available

Educational Packet and Materials

Updated and translated tote request cards and awareness materails will be available from our office.

2024 OPPORTUNITIES

SURVIVOR SEMINAR

A day of programming focused on survivorship and connection

EDUCATIONAL SERIES

In person and virtual programs for survivors and caregivers

THANK YOU!

MEGAN NEUBAUER
MEGANNEUBAUER@MIOCA.ORG
734-800-6144

MIOCA/MOQC Survey

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

MOQCLink Dashboards

Keli DeVries, LMSW

Vanessa Aron, BA

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MOQCLink & Reports Timeline

- VBR dates
- Gyn Onc meeting dates

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Dashboard Access

Usernames and passwords

- Post-Biannual emails
- Physician Champion/Administrative Champion
- Additional access can be requested

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Dashboard Reports

Feedback

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Live Demo

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MOQC Updates

Jennifer Griggs, MD, MPH

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MOQC Updates

Jennifer Griggs, MD, MPH

- Strategic Objectives, 2024 - 2025
- Opportunities for Collaboration
- Equity Work across MOQC
- MOQC Certification

Strategic Objectives, 2024 - 2025

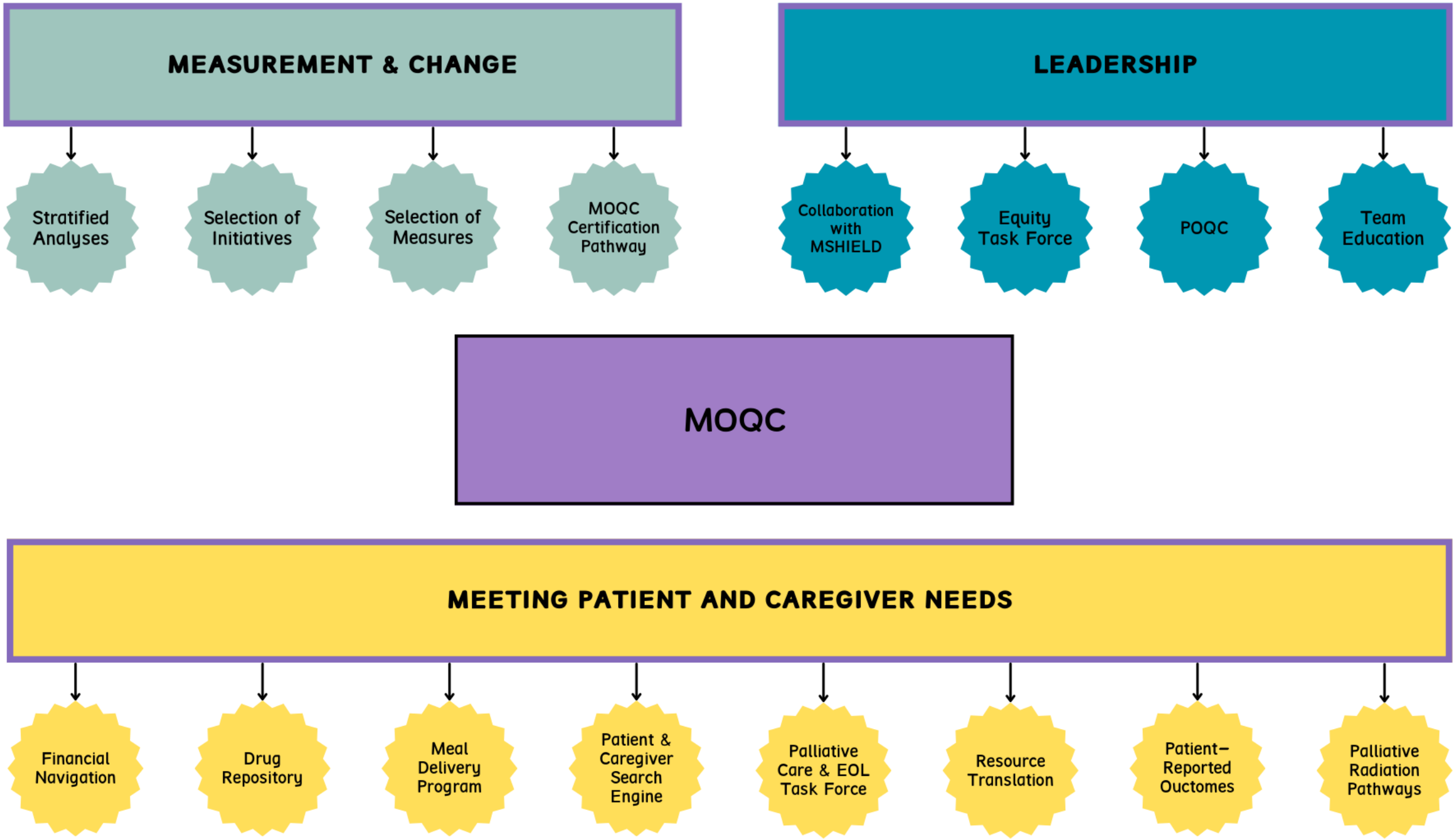
Maximize value

Center Equity

Foster professional development

Equity Task Force Members

- **Hadeel Assad**
- **Lydia Benitez Colon**
- **Tracey Cargill-Smith**
- **Michael Dudley**
- **Suzanne Fadly**
- **Cindy Fenimore**
- **Beth Fisher-Polasky**
- **Zachary Hector-Word**
- **Yelena Kier**
- **Sharon Kim**
- **Geetika Kukreja**
- **Beth Sieloff**
- **Diane Smith**
- **Elena Stoffel**
- **Shannon Wills**


MEASUREMENT & CHANGE
Stratified Analyses
Selection of Initiatives
Selection of Measures
MOQC Certification Pathway
LEADERSHIP
Collaboration with MSHIELD
Equity Task Force
POQC
Team Education
MOQC
MEETING PATIENT AND CAREGIVER NEEDS
Financial Navigation
Drug Repository
Meal Delivery Program
Patient & Caregiver Search Engine
Palliative Care & EOL Task Force
Resource Translation
Patient–Reported Ouctomes
Palliative Radiation Pathways

Steering Committee Members

- Aimee Ryan
- Ammar Sukari
- Beth Sieloff
- Colleen Schwartz
- Cynthia Koch
- Dawn Severson
- Diana Kostoff
- Diane Drago
- Mike Harrison
- Heather Spotts
- Kate Schumaker
- Kathy LaRaia
- Kevin Brader
- Michele Lore
- Mike Stellini
- Nick Erikson
- Padma Venuturmilli
- Shannon Wills
- Sherry Levandowki
- Tim Cox
- Tom Gribbin
- Tracey Cargill-Smith

Measures Committee Members

- John Bartnik
- Kathleen Beekman
- Tracey Cargill-Smith
- Diane Drago
- Llewellyn Drong
- Michael Harrison
- Sharon Kim
- Diana Kostoff
- Kathy LaRaia
- Colleen Schwartz
- Jerome Seid
- Dawn Severson
- Ammar Sukari
- Padmaja Venuturumilli
- Shannon Wills
- Laura Winningham
- Taylor Wofford

MOQC Certification

12% VBR

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MOQC Certification Task Force

- Taylor Taylor
- Gordan Srkalovic
- Tracey Cargill-Smith
- Stephanie Ackerman
- Irene Turkewycz
- Patrice Tims
- Megan Beaudrie
- Renae Vaughn
- Rebecca Gallegos
- Tanya Rowerdink
- Andrew Porter
- Cindy Michelin
- Stephanie Kretz
- Diane Drago

Certification Proposal September 2023

MOQC Certification Measures

Measure Number	MOQC Pathway Measure
101b	Tobacco cessation counseling administered, or patient referred in past year
111	GCSF administered to patients who received chemotherapy for non-curative intent (lower score – better)
115	NK1RA & olanzapine for high emetic risk chemotherapy
126c	Enrolled in hospice for over 30 days
127	Chemotherapy administered within the last 2 weeks of life (lower score - better)
130	Beginning a new anti-cancer regimen within 14 days of death (lower score better)
118	Giving anti-cancer therapy to people with PS ≥ 3 & no response to 2 previous regimens (lower score better)
129	Palliative care consultation more than 90 days before death
103	Designated advocate documented on a legally recognized document in the outpatient medical record
123	Days from debulking surgery to chemotherapy (Gyn Onc only)
116	Median opioid prescribing (meas. as oxycodone tablets, equiv) following surgical procedure (Gyn Onc only)

MOQC Certification Measures

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116	Median opioid prescribing (oxycodone tablet equivalent) following surgical procedure (Gyn Onc only)

New measures indicated in bold

Resources Overview and Closing

Vanessa Aron, BA

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2024 MOQC Medical Oncology January Biannual

Friday, January 19, 2024

Virtual

Centering Equity in Cancer Care

Keynote Speaker: **Karen Winkfield, MD, PhD**

Professor of Radiation Oncology
Ingram Professor of Cancer Research
Executive Director, Meharry-Vanderbilt Alliance

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2024 MOQC Gynecologic Oncology Spring Biannual

Dr. Brittany Davidson
Duke Health

Friday, May 3, 2024
10:00am - 4:00pm

The Inn at St. John's
Plymouth, MI

DukeHealth

Newsletter

Practice and Patient/Caregiver Spotlights

Please email:

moqc@moqc.org

FROM THE

Program Director

We're sending this out after an extremely successful June Biannual Meeting. Reading that, you may wonder how we define "success". Success is a reflection of your engagement and your feedback. Read on to learn more about the highlights of the meeting.

We are so excited to report that the MOQC Certification Pathway was approved by our partners at BCBSM. Many thanks to the MOQC Certification Task Force members. Practices will be invited to apply for certification, associated with a 12% VBR, in the fall. In the meantime, we are seeking your comments and questions. You have received an email with everything you need to know about certification and a brief Qualtrics form during the Open Comment period from June 20 - July 20. Please read through the description of the certification pathway and let us know what questions, ideas, and comments you have. We will make any revisions that are in line with the purpose and possibility of the proposal before finalizing it.

We are pleased to announce that MOQC received a grant to explore and develop a statewide oncology stewardship program. This idea was born based on your appetite for harmonizing care across Michigan. You may remember that, during and after the January Biannual Meeting, Lydia Benitez, PharmD, BCOP reviewed the principles of stewardship in our field. During the spring regional meetings, we collected names of hematologists-oncologists whom you nominated across the state. We are inviting those you nominated to be part of this effort.

We are also pleased to report that MOQC and Healthy Behavior Optimization for Michigan (HBOM) received a grant to conduct a pilot of providing free meals and meal delivery to patients experiencing food insecurity. We will be disseminating more information soon. The long-term goal is to obtain a large federal or foundation grant to extend this work throughout the state.

We look forward to meeting you in your practice (either in person or via Zoom) to review your data, find out more about what you need to meet your patient care and performance goals, and to share resources that we have. The real reason to meet with you, however, is to learn from you as we always do.

Have a wonderful summer,

Dr. Jennifer Griggs
Program Director

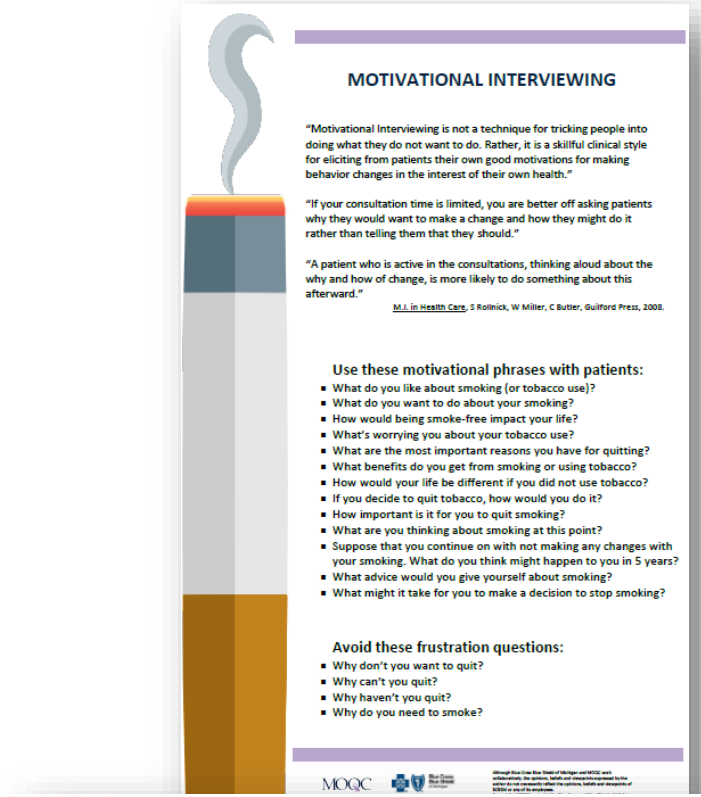
Site Visits

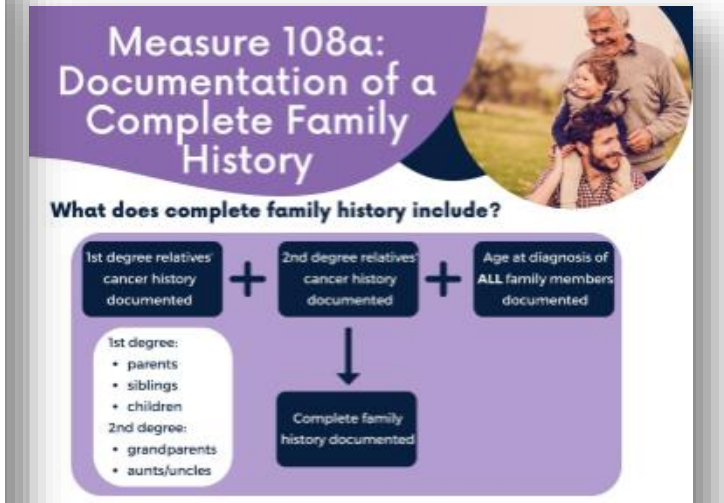
- Schedule a site visit with MOQC
  - Review practice performance
  - Celebrate successes
  - Brainstorm ideas for performance improvement on specific measures
  - Review resources available
- In-person and virtual options are available

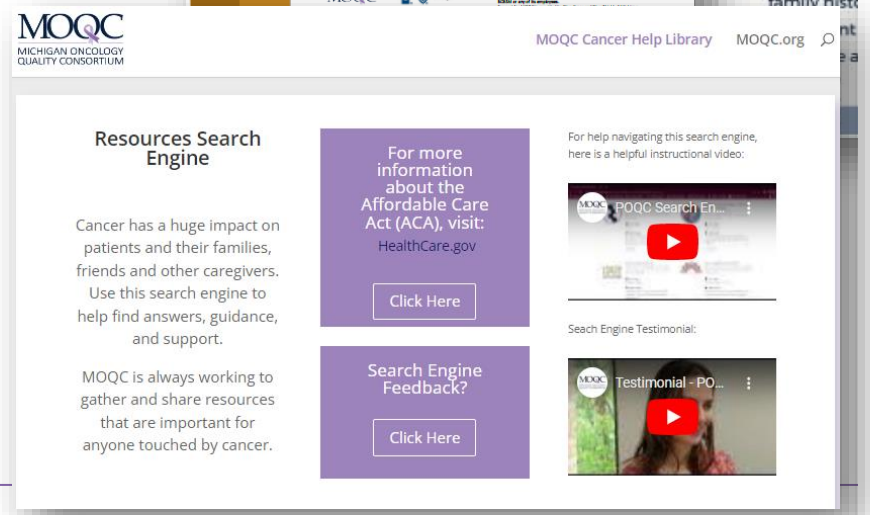
MOQC Resources

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

www.moqc.org







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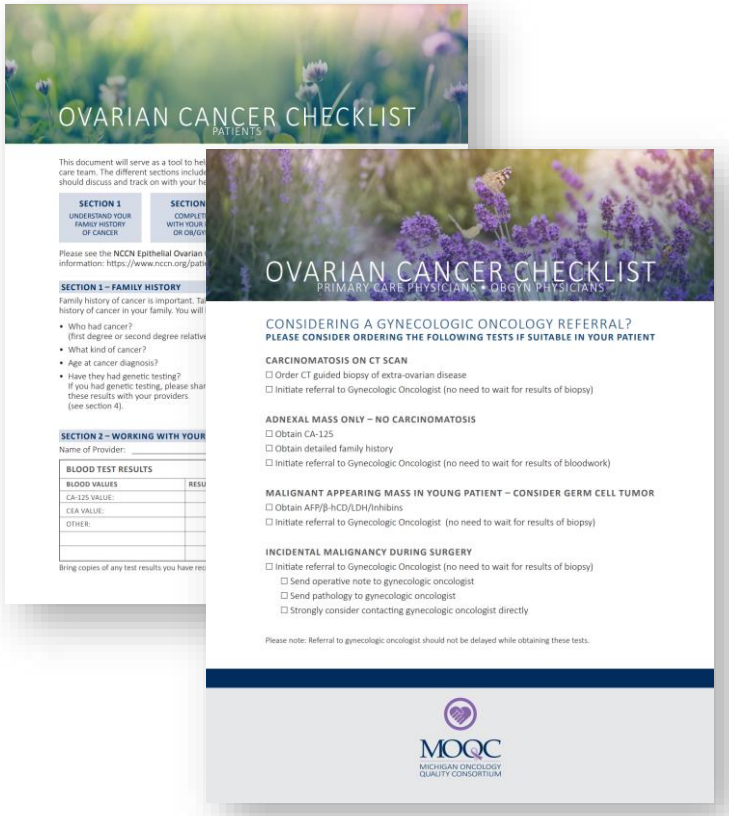
MOQC Resources

We would love to meet with your staff!



www.ovariancancerpodcast.com

OVARIAN CANCER EDUCATION

Continuing Education Credits

Group	Number of Credits
Physician/Nurse	5.0

Continuing Education Credits

Steps to create a MiCME Account:

1. Go to https://ww2.highmarksce.com/micme/
2. Click the “Create a MiCME Account” tile at the bottom of the screen
3. Under New User? click “Create a MiCME Account”
4. Enter the Profile Information questions, confirm consent, and click “Create a MiCME Account”
5. Enter your password and complete your profile. Your MiCME account is created, and you can now claim continuing education credits

Steps to Claim Credits and Print a Transcript

1. Once your MiCME account has been created, navigate to your Dashboard
2. Click on *Claim Credits and View Certificates*
3. Locate ‘**MOQC Gynecology Oncology Fall 2023 Meeting**’ in the *Activities Available for Credit Claiming* section
4. Under Action, click on *Claim*. *Add Credit.*
5. Enter the number of credits you are claiming and the *“I Attest”* button.
6. Complete the evaluation.
7. Click the *Submit* button.
8. Scroll down to the *Awarded Credits* section to view or print your certificate and/or comprehensive University of Michigan CME transcript.

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

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Thank You