# Agenda

## Morning Session | 10 am

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00-10:30</td>
<td>Welcome and Overview POQC Update Steering Committee Update Equity Task Force Update</td>
<td>Keli DeVries, LMSW POQC Members Dawn Severson, MD Sharon Kim</td>
</tr>
<tr>
<td>10:30-11:15</td>
<td>MOQC Practice Performance &amp; Discussion</td>
<td>Jennifer Griggs, MD, MPH</td>
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<tr>
<td>11:15-11:25</td>
<td>Break</td>
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<td>11:25-11:35</td>
<td>The Voice of the Caregiver</td>
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<td>11:35-12:35</td>
<td>Keynote Speaker</td>
<td>Thomas LeBlanc, MD, MA, MHS</td>
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<td>Associate Professor of Medicine</td>
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<td>Duke Cancer Institute</td>
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## Lunch | 12:35 pm

12:35-1:05 Break for lunch

## Afternoon Session | 1:05 pm

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<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter(s)</th>
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<tbody>
<tr>
<td>1:05-1:30</td>
<td>Palliative Care and End-of-Life Task Force Update Palliative Radiation Pathways</td>
<td>Tom O'Neil, MD Jennifer Griggs, MD, MPH</td>
</tr>
<tr>
<td>1:30-2:25</td>
<td>Harnessing Patient-Reported Outcomes for Symptom Management and Decision Making • PROs Initiative Update</td>
<td>Steven Chang, MD Samantha Tam, MD Ashley Bowen, MS, RD, CHC</td>
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<tr>
<td>2:25-2:35</td>
<td>Break</td>
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<tr>
<td>2:35-3:05</td>
<td>Palliative Care Access &amp; Referral Patterns: A Tale of Two Surveys</td>
<td>Andrew Russell, MD, MPH</td>
</tr>
<tr>
<td>3:05-3:50</td>
<td>Responding to Patient Needs – Embedding Pharmacists in Oncology Practices with POEM</td>
<td>Emily Mackler, PharmD, BCOP Mark Wagner, PharmD, BCOP Katie Sias, Pharm D, BCOP</td>
</tr>
</tbody>
</table>

## Close | 3:50 pm

3:50-4:00 Closing Items Keli DeVries, LMSW
Meeting Details

WIFI Network: The_H_Hotel

Lactation + Prayer Rooms Available
Restroom locations

Masks are available

Registration desk staffed all day
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.
360 Evaluation

MOQC has great value for oncology in Michigan in bringing together practices across the state, sharing data across the country, as well as presenting the patient care perspective in oncology treatments, palliative care and comfort care.

Physician

MOQC lives up to its mission - improvement of quality of care for patients. The intent is genuine. MOQC listens to the participating practices and offers valuable content and resources to achieve improvement in quality.

Physician

MOQC’s biggest strength is the presentation of data from all practices. It is helpful being able to compare how we are doing and find areas of improvements.

Pharmacist

I enjoy collaborating with other practices to look at best workflows. I appreciate MOQC’s focus on equity and how we can all make sure patients receive high quality care.

Practice Manager

I appreciate the care and focus that MOQC provides to patients and caregivers. MOQC holds physicians and practices to a higher standard for patient care.

POQC Member
Disclosure Statement

As a Jointly Accredited Provider of Interprofessional Continuing Education Credit, the National Center for Interprofessional Practice and Education Office of Interprofessional Continuing Professional Development (OICPD) complies with the ACCME and Joint Accreditors’ Standards for Integrity and Independence in Accredited Continuing Education. The National Center has a conflict of interest policy that requires all individuals involved in the development, planning, implementation, peer review and/or evaluation of an activity to disclose any financial relationships with ineligible companies. The National Center performs a thorough review of the content of the accredited activity to ensure that any financial relationships have no influence on the content of accredited activities. All potential conflicts of interest that arise based on these financial relationships are mitigated prior to the accredited activity.
Disclosures

The following planners and presenters have disclosed a financial relationship with an ineligible company:

- **Thomas LeBlanc** -
  - Speaker's bureau and consultant with AbbVie/Genentech;
  - Speaker's bureau with Agios and BMS;
  - Speaker's bureau, research funding and consultant with BMS/Celgene;
  - Research funding and consultant with AstraZeneca, CareVive, GSK;
  - Research funding from Deverra Therapeutics, Jazz Pharmaceuticals, Seattle Genetics, Janssen;
  - Consultant with Astellas, BlueNote, Flatiron, Novartis, Pfizer;
  - Honorarium from Incyte

- **Emily Mackler** -
  - Grant from AstraZeneca

- **Mark Wagner** -
  - Speaker's bureau with AstraZeneca, Merck, Mitati, and Genentech

- **Samantha Tam** -
  - Grant from Genentech

These planners and presenters have attested that these financial relationships in no way affects their planning or delivery of content in this accredited activity.

There are no conflicts of interest or financial relationships with an ineligible company that have been disclosed by the rest of the planners and presenters of this learning activity.
In support of improving patient care, this activity is planned and implemented by The National Center for Interprofessional Practice and Education Office of Interprofessional Continuing Professional Development (OICPD) and the Michigan Oncology Quality Consortium. The National Center OICPD is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

**Physicians:** The National Center OICPD designates this activity for a maximum of **5.25 AMA PRA Category 1 Credit(s)™.** Physicians should only claim credit commensurate with their participation.

**Nurses:** Participants will be awarded up to **5.25 contact hours of credit for attendance at this activity.**

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

**Pharmacists and Pharmacy Technicians:** This activity is approved for **5.25 contact hours (.525 CEU)**

**Social Workers:** As a Jointly Accredited Organization, the National Center OICPD is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. The National Center OICPD maintains responsibility for this course. Social workers completing this course receive up to **5.25 continuing education credits.**

**Athletic Trainers:** The National Center OICPD (JA#: 4008105) is approved by the Board of Certification, Inc. to provide continuing education to Athletic Trainers (ATs). This program is eligible for a maximum of **5.25 Category A hours/CEUs.** ATs should claim only those hours actually spent in the educational program.

**IPCE:** This activity was planned by and for the healthcare team, and learners will receive **5.25 Interprofessional Continuing Education (IPCE) credits for learning and change**
MOQC Resources

- MOQC has a variety of free resources for your patients, caregivers, and practice sites

- Virtual and printed formats available

- https://www.moqc.org/resources/
MOQC Resources

MOQC has resources available in these languages:
• Arabic
• Chinese (Mandarin)
• English
• Spanish
• Vietnamese

What other languages would be helpful for your patients and caregivers?

Submit your response: slido.com
#3241 511
MOQC Resources

- Measure videos
- Measure information sheets
MOQC Patient Reported Outcomes Testing

Check out the PROs test site and tablets at the MOQC resources table!
MOQC Update: Transitions

Ermili Potka

Manlan Liu
MOQC Update: New Team Members

Jennifer Broadhurst
Clinical Data Abstractor

BSN Northern Illinois University
Outpatient Infusion Nurse
Oncology Certified Nurse 2020
Soon to be Certified Tumor Registrar

“I am excited to join MOQC because I believe in the mission!”
MOQC Update: New Team Members

Deana Jansa (she/her)
Clinical Data Abstractor

BSN University of Wisconsin-Madison
MHA University of Phoenix
Oncology care experience
Research and quality improvement

“I am thrilled to join MOQC and help improve care for patients!”
MOQC Update: New Team Members

Eric Voisine
Data Analyst/Visualization Specialist

MS in Data Science and Analytics
Michigan State University
Experience as IT Auditor and Data Engineer
Enabling access to and understanding data

“I’m excited to work with a team of compassionate people to learn as much as I can.”
2022 Practice Award Winners

Cancer & Hematology Centers of Western Michigan
- Marcia Rau, Covenant
- Amy Hawkins, Henry Ford Allegiance
- Kevin Brader, University of Michigan Health West
- Newland Medical Associates
- Jennifer Metevia, Oncology Hematology Associates of Saginaw Valley
- Bronson Cancer Center
- Beaumont Gynecologic Oncology

Jerome Seid, Great Lakes Cancer Management Specialists
- Stacy Lattin, MHP Oakland Medical Group
- Kelly Bristow, Henry Ford Health
- Laura Johnson, Munson Healthcare
- Bryan Schneider, Michigan Medicine Rogel Cancer Center
- Marcia Rau & Jennifer Blakeslee-Wilber, Covenant
- Ayham Ashkar, MHP Oakland Medical Group
- Melissa Steller, Sparrow Health System

Growth Mindset  Trust & Integrity  Collaboration  Compassion
2023 Award Winners!

University of Michigan Health West Gyn Onc

Megan Beaudrie, Karmanos Cancer Institute

Karmanos Cancer Institute

And more to come...
POQC Update

Steve Clark
Tracey Cargill-Smith
Mike Harrison
Diane Drago
POQC Update

Recruitment & Retention

Financial Navigation

Patient & Caregiver Resources

For questions and follow-up email moqc@moqc.org
Steering Committee Report

Dawn Severson, MD
Steering Committee Report

• MOQC Certification Update
  Open comment period for all MOQC sites begins week of June 19, 2023

• Interprofessional development
  MOQC will be creating learning opportunities & resources for all members of your practice

• Cancer drug repository moving forward
  Dr. Mackler presenting later this afternoon
Upcoming Medical Oncology Meetings

2023 Fall Regionals
Tobacco Cessation

2024 January Biannual
Equity in Cancer Care

2024 June Biannual
Clinician & Team Flourishing
Debate—pros & cons of multicancer early detection
Equity Task Force Update

Sharon Kim
Equity Task Force Update

MEASUREMENT
- Equity Analyses
- Selection of Initiatives
- Measure Selection
- MOQC Certification Pathway

LEADERSHIP
- MSHIELD Health Equity Champions
- Equity Task Force
- POQC Recruitment
- Team Education

MOQC

MEETING PATIENT AND CAREGIVER NEEDS
- Financial Navigation
- Drug Repository
- Food Delivery Program with HBOM
- Patient and Caregiver Search Engine
- Palliative and EOL Task Force
- Resource Translation
- PROs Initiative
- Palliative Radiation Pathways
Equity Task Force Update

Multivariate Analysis of MOQC Data

Mayo Clinic’s Patient Navigation Program

Community Partnerships
MOQC Practice Performance & VBR Updates

Jennifer J. Griggs, MD, MPH
## 2023 Medical Oncology Measures

<table>
<thead>
<tr>
<th>MOQC Pathway Measure</th>
<th>VBR Measure</th>
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<tbody>
<tr>
<td>Complete family history documented for patients with invasive cancer</td>
<td>x</td>
</tr>
<tr>
<td>Tobacco cessation counseling administered, or patient referred in past year</td>
<td>x</td>
</tr>
<tr>
<td>GCSF administered to patients who received chemotherapy for non-curative intent</td>
<td></td>
</tr>
<tr>
<td>(lower score – better)</td>
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</tr>
<tr>
<td>NK1RA for low or moderate emetic risk cycle 1 chemotherapy (lower score – better)</td>
<td>x</td>
</tr>
<tr>
<td>NK1RA &amp; olanzapine for high emetic risk chemotherapy</td>
<td>x</td>
</tr>
<tr>
<td>Hospice enrollment</td>
<td>x</td>
</tr>
<tr>
<td>Enrolled in Hospice for over 7 days</td>
<td></td>
</tr>
<tr>
<td>Enrolled in Hospice for over 30 days</td>
<td></td>
</tr>
<tr>
<td>Hospice enrollment within 7 days of death (lower score – better)</td>
<td>x</td>
</tr>
<tr>
<td>Chemotherapy administered within the last 2 weeks of life (lower score - better)</td>
<td></td>
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</tbody>
</table>
# 2023 Medical Oncology Measures: Changes

<table>
<thead>
<tr>
<th>New VBR Measure</th>
<th>VBR Measure</th>
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</thead>
<tbody>
<tr>
<td>Complete family history documented for patients with invasive cancer</td>
<td>X</td>
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</table>

<table>
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<tr>
<th>Measures Retiring from VBR</th>
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<tbody>
<tr>
<td>Completeness of race and ethnicity data</td>
</tr>
<tr>
<td>Smoking status recorded in medical record</td>
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</table>
2023 Value-Based Reimbursement Summary

**Region-Level**
Meet 4 of the following 5

- NK1RA & olanzapine given with high emetic risk chemotherapy 30%
- NK1RA given for low or moderate emetic risk cycle 1 chemotherapy 10%
- Hospice enrollment 60%
- Hospice enrollment within 7 days of death 35%
- Complete family history documented 35%

3% Opportunity

**Practice-Level**

- Meet all 5 region-level measures

2% Opportunity

**Collaborative-Wide**

- Tobacco cessation counseling administered or patient referred in past year 70%

2% Opportunity
## Additional Criteria for Receiving VBR

<table>
<thead>
<tr>
<th>Level</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Practice Level</strong></td>
<td>At least one physician and one practice manager from the practice must attend both MOQC regional meetings and at least one biannual meeting during that year</td>
</tr>
<tr>
<td><strong>Physician Level</strong></td>
<td>Provider must be enrolled in PGIP for at least one year</td>
</tr>
</tbody>
</table>
Thank You, Data Abstractors

- Tracy Messing, MHP Hematology Oncology Consultants
- Nick Casabon, MHP Hematology Oncology Consultants
- Denise Gregoire, MHP Downriver
- Julie Boylan, Hematology Oncology Consultants
- Aimee Ryan, Great Lakes Cancer Management Specialists
- Ashley Poulin, Great Lakes Cancer Management Specialists
- Adrienne Stevens, Great Lakes Cancer Management Specialists
- Amy Flietstra, Cancer & Hematology Centers

- Alexandra Gehrke, Cancer & Hematology Centers
- Amy Morgan, Geneseed Hematology Oncology
- Mary Nicholson, Geneseed Hematology Oncology
- Vicky Reyes, Geneseed Hematology Oncology
- Joanna Gil, Henry Ford Cancer Institute
- Kelly Bristow, Henry Ford Cancer Institute
- Lisa May, Henry Ford Cancer Institute
- Cheryl Ryan, Henry Ford Cancer Institute
- Holly Boyle, Henry Ford Cancer Institute
- Vanessa Schroeder, Henry Ford Cancer Institute
- Lori Longhrige, Huron Medical Center
- Katie Dombecki, Huron Medical Center
- Alicia Kehoe, Huron Medical Center
Thank You, Data Abstractors

- Vickie Foley, Karmanos Bay Oncology Hematology
- Wendy Mielens, Karmanos Bay Oncology Hematology
- Amanda Boisvert, Karmanos Cancer Institute at McLaren Macomb
- Jeanie Rye, Memorial Healthcare Cancer Center
- Roxy Salam, Cancer & Leukemia Center
- Kelly Guswiler, Munson Oncology
- Renae Vaughn, Munson Oncology
- Angela Gorham, West Michigan Cancer Center & Institute for Blood Disorders
- Erika Burkland, Dickinson Hematology/Oncology Clinic
- Cynthia Keyton, KCI McLaren Greater Lansing Hospital
- Heather Spotts, KCI McLaren Greater Lansing Hospital
- Jeanne Melton, KCI McLaren Northern Michigan Hem Onc

MOQC Team & MOQC by Proxy

Kleanthe Kolizeras, Heather Behring, Cindy Michalek, Heather Rombach, Deborah Turner, Shawn Winsted, Colleen Schwartz, Therese Hecksel
Measures

• ▲ or ▼ indicates statistically significant improvement or worsening in performance between time periods (p< 0.05)

• Practices with no eligible cases in the denominator and/or missing data from one of the time periods are not shown
Complete family history document for patients with invasive cancer (108a) (n = 6552)
Tobacco cessation counseling administered or patient referred in past year (101b)\( (n = 1122)\)

**Target = 70%**

<table>
<thead>
<tr>
<th>Practice</th>
<th>Denom.:</th>
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<tbody>
<tr>
<td>43</td>
<td>18</td>
</tr>
<tr>
<td>30</td>
<td>25</td>
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<td>15</td>
<td>95</td>
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<td>25</td>
<td>96</td>
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**Performance, %**

- VBR Measure (n = 1122)
GCSF administered to patients who received chemotherapy for non-curative intent (111) (n = 1244)

Target = 10% (lower=better)
NK1 receptor antagonist prescribed or administered for low or moderate emetic risk cycle 1 chemotherapy (114) (n = 2243)

Target = 10% (lower=better)
NK1 receptor antagonist and olanzapine prescribed or administered with high emetic risk chemotherapy (115) (n = 1908)
End-of-Life Measures
Hospice enrollment (126a) (n = 3081)

Target = 60%

Performance, %

Practice:

Denom.: 35 31 106 65 23 222 24 67 83 73 54 66 76 9 77 41 26 31 0 20 40 60 80 100

VBR Measure (n = 3081)
Hospice enrollment more than 7 days before death (126b)(n = 820)

Target = 60%
Hospice enrollment more than 30 days before death (126c) (n = 820)

Target = 30%
Hospice enrollment within 7 days of death (EOL45) (n = 1865)
Target = 35% (lower=better)
Chemotherapy administered within the last 2 weeks of life (127)(n = 3101)

Target = 10% (lower=better)
Discussion

Submit your questions:
slido.com
#3241 511
Break
The Voice of the Caregiver
Improving Cancer Care Quality through Palliative Care Integration

Thomas W. LeBlanc, MD, MA, MHS, FAAHPM, FASCO
Associate Professor of Medicine with Tenure
Division of Hematologic Malignancies

Director, Cancer Patient Experience Research Program (CPEP)

Chief Patient Experience and Safety Officer
Objectives

At the conclusion of this session, the participants will be able to

1. Explain the benefits of early concurrent specialist palliative care in patients with advanced cancer, citing data from multiple randomized controlled trials

2. Select patients with malignancy in whom the inclusion of palliative and supportive care specialists is warranted, including those receiving curative intent therapies like stem cell transplantation

3. Propose models for integrating models of palliative care and expanding access to care for patients who have difficulty accessing such care in their practice
Outline

• Case

• Palliative Care: a 21st Century Definition

• Palliative care needs in hematologic malignancies

• Data on integrated care, and outcomes
QUESTION 1: DOES JEAN NEED PALLIATIVE CARE?

Submit your response: slido.com #3241 511
QUESTION 2:
DO YOU HAVE ACCESS TO OUTPATIENT SPECIALIST PALLIATIVE CARE IN YOUR PRACTICE?

Submit your response:
slido.com
#3241 511
WHAT IS PALLIATIVE CARE?
...SPECIALIZED MEDICAL CARE FOR PEOPLE FACING A SERIOUS ILLNESS

CAPC.org definition
...FOCUSES ON PROVIDING PATIENTS WITH RELIEF FROM THE SYMPTOMS AND STRESS OF A SERIOUS ILLNESS

CAPC.org definition
...GOAL IS TO IMPROVE QUALITY OF LIFE FOR THE PATIENT AND FAMILY

CAPC.org definition
…provided by a specially-trained team of doctors, nurses, and other specialists who work together with a patient’s other doctors to provide an extra layer of support.

CAPC.org definition
...IT IS APPROPRIATE AT ANY AGE AND AT ANY STAGE IN A SERIOUS ILLNESS AND CAN BE PROVIDED ALONG WITH CURATIVE TREATMENT

CAPC.org definition
WHO PROVIDES IT?
The Workforce

ABMS recognized “hospice and palliative medicine” as a board certified subspecialty in 2006

- > 8,000 boarded specialists in the US
  - > 100 fellowship training programs
  - Fellowship training required since 2013 (1 year)

>90% of US hospitals >300 beds have palliative care

HOWEVER, most palliative care for patients with cancer is provided by their cancer care team
Primary vs. Specialty Palliative Care

**Primary palliative care:**
- Pain management
- CINV prevention/tx
- Symptom mgt
- Psychological support
- Prognostic discussions, goals of care

**Specialty palliative care:**
- Complex, refractory symptoms
- Persistent distress, coping
- Complex communication, poor understanding of prognosis
- Advance directives, legacy planning
- Family/caregiver support

Quill TE and Abernethy AP. "Generalist plus specialist palliative care – creating a more sustainable model." *NEJM*, 2013
WHAT DO PALLIATIVE CARE SPECIALISTS DO?
Core Competencies

• Symptom management
  • Complex/refractory symptom management

• Communication
  • Difficult communication / conflict resolution
  • Facilitating prognostic understanding; aid in decisions

• Psychosocial distress assessment and management

• Spiritual assessment and support

• Family and caregiver care

• End-of-life care (including hospice)
Different Focus

Patients talk about different things with their oncologist than they do with their palliative care specialist.

Three primary foci of palliative care visits in oncology:

1. Symptom management
2. Engaging patients in emotional work
3. Serving as communication bridge

*This should not replace the “primary palliative care” that most of us already provide.

Figure 2. Elements of palliative care (PC) vs oncologic care visits at clinical turning points. EOL indicates end of life.
Integrated Palliative Care Studies in Oncology

Many randomized clinical trials:
- Bakitas et al, JAMA 2009, ENABLE II study
- Temel et al, NEJM 2010
- Zimmerman et al, Lancet 2014
- Bakitas et al, JCO 2015, ENABLE III study
- Grudzen et al, JAMA Oncology 2016
- Temel et al, JCO 2016
- El-Jawahri et al, JAMA 2016, SHIELD study
- Vanbutsele et al, Lancet Onc 2018
- El-Jawahri and LeBlanc, JAMA Onc 2020, LEAP trial

Many patient-centered outcome improvements
- Starting to see long-term and caregiver outcomes improve

No study has shown harm
Improved outcomes in these studies

- Quality of life
- Symptom management
- Mood/depression
- Prognostic understanding
- Caregiver outcomes
- Utilization/costs
- Satisfaction
- End-of-life outcomes
- Survival
Professional Society Recommendations

• **American Society of Clinical Oncology**
  - “any patient with metastatic cancer and/or high symptom burden”

• **American College of Surgeons, Commission on Cancer**
  - Accredited programs “required to offer palliative care either on site or by referral”

• **National Comprehensive Cancer Network**
  - “Institutions should develop processes for integrating palliative care into cancer care, both as part of usual oncology care and for patients with specialty palliative care needs”

• **Oncology Nursing Society**
  - “All patients with cancer benefit from palliative care”
  - “Palliative care should begin at time of diagnosis”

ONS Position Statement: Palliative Care for People With Cancer: https://www.ons.org/advocacy-policy/positions/practice/palliative-care
QUESTION 3: WHAT PROPORTION OF YOUR PATIENTS WITH ADVANCED CANCER ARE REFERRED TO PALLIATIVE CARE BEFORE END OF LIFE?

Submit your response: slido.com #3241 511
WHAT ARE THE PALLIATIVE AND END-OF-LIFE CARE NEEDS OF HEMATOLOGY PATIENTS?
54%
81%
39%
43%
57,230

40,610
Unmet End-of-Life Needs in Hematologic Malignancies

Outcomes: The “Quality Measures” Gap

• Patients with blood cancers are more likely to: \(^1,2\)
  – receive chemotherapy in the last 14 days of life
  – spend time in an ICU in the last 30 days of life

• Patients with blood cancers are less likely to:
  – access consultative palliative care services\(^3\)
  – use hospice services\(^4\)
    • Or, are more likely to die within 7 days of enrollment, or within 24 hrs of enrollment \(^5\)
    • Median LOS of 11 days, vs. 19 for solid tumors \(^5\)

Burden of Care in AML

**Health care use**
- Percent life in hospital: 28%
- Percent life in clinic: 14%
- Percent life outside hospital or clinic: 58%

**Place of death**
- Home without hospice: 61%
- Facility or hospice home: 22%
- Hospital: 17%

- Median hospitalizations = 4.2
- ICU admissions = 31.7%
- Palliative care consult = 16.2%
- Hospice utilization = 22%

---

El-Jawahri, Cancer 2015
Unmet Symptom Needs in Hematologic Malignancies

Symptom Burden

DOES PALLIATIVE CARE WORK IN HEMATOLOGY?
Randomized Trial of Inpatient Palliative Care Intervention for Patients Hospitalized for Hematopoietic Stem Cell Transplantation (HCT)

Areej El-Jawahri, Thomas LeBlanc, Harry VanDusen, Lara Traeger, Joseph Greer, William Pirl, Vicki Jackson, Jason Telles, Alison Rhodes, Thomas Spitzer, Steven McAfee, Yi-Bin Chen, Stephanie Lee, Jennifer Temel
Study Design

160 patients with hematologic malignancies within 72 hour of admission for HCT (and their willing family caregivers)

**Randomized**

- **Inpatient Integrated Palliative and Transplant Care**
  - At least 2 visits weekly during HCT hospitalization.

- **Transplant Care Alone**
  - Palliative care consult upon request.

**Longitudinal data collection**
- Week 2 (primary)
- Three & six months post HCT
Assessed for eligibility N=242

Enrolled and Randomized N=160 (86%)

Ineligible (N = 56)
- Eligible but refused N = 26
  - Dislike survey (N = 10)
  - Too anxious (N = 5)
  - Concerned about logistics (N = 5)
  - No reason (N = 5)

Transplant care (N = 79)

Week-2 assessment
Completed N=77 (97.5%)

3-month assessment
 Completed N=74 (93.7%)

Inpatient palliative care (N =81)

Week-2 assessment
Completed N=80 (98.8%)

3-month assessment
Completed N=75 (92.6%)
Patient QOL

\[ \Delta \text{FACT-BMT}: -14.7 \text{ vs. } -21.5 \]

\[ P = 0.04, \text{ Cohen's d} = 2.9 \]
\[ \Delta \text{ESAS: } 17.3 \text{ vs. } 23.1 \]

\[ P = 0.03, \text{ Cohen's } d = 0.4 \]
**Patient Mood**

Δ HADS-D: 2.4 vs. 3.9,  
**P = 0.02**, Cohen’s d = 0.4

Δ HADS-A: -0.8 vs. 1.1  
**P = 0.0006**, Cohen’s d = 0.6
### Week-2 Outcomes

<table>
<thead>
<tr>
<th>Week-2 Outcomes</th>
<th>Adjusted mean difference</th>
<th>95% CI</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>FACT – BMT (primary outcome)</td>
<td>7.73</td>
<td>1.27 to 14.19</td>
<td>0.019</td>
</tr>
<tr>
<td>FACT – Fatigue</td>
<td>3.88</td>
<td>0.21 to 7.54</td>
<td>0.038</td>
</tr>
<tr>
<td>ESAS – Symptom burden</td>
<td>-6.26</td>
<td>-11.46 to -1.05</td>
<td>0.019</td>
</tr>
<tr>
<td>HADS – Depression symptoms</td>
<td>-1.74</td>
<td>-3.01 to -0.47</td>
<td>0.008</td>
</tr>
<tr>
<td>HADS – Anxiety symptoms</td>
<td>-2.26</td>
<td>-3.22 to -1.29</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>PHQ-9 – Depression</td>
<td>-1.28</td>
<td>-2.82 to 0.27</td>
<td>0.104</td>
</tr>
</tbody>
</table>
### 3 Month Outcomes

<table>
<thead>
<tr>
<th>3 Month Outcomes</th>
<th>Adjusted mean difference</th>
<th>95%CI</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>FACT – BMT</td>
<td>5.34</td>
<td>0.04 to 10.65</td>
<td>0.048</td>
</tr>
<tr>
<td>FACT – Fatigue</td>
<td>2.00</td>
<td>-1.08 to 5.09</td>
<td>0.202</td>
</tr>
<tr>
<td>ESAS – Symptom burden</td>
<td>-2.44</td>
<td>-6.29 to 1.41</td>
<td>0.212</td>
</tr>
<tr>
<td>HADS – Depression symptoms</td>
<td>-1.70</td>
<td>-2.75 to -0.65</td>
<td>0.002</td>
</tr>
<tr>
<td>HADS – Anxiety symptoms</td>
<td>-0.76</td>
<td>-1.73 to 0.23</td>
<td>0.130</td>
</tr>
<tr>
<td>PHQ-9 – Depression</td>
<td>-2.12</td>
<td>-3.42 to -0.814</td>
<td>0.002</td>
</tr>
<tr>
<td>PCL – PTSD symptoms</td>
<td>-4.35</td>
<td>-7.12 to -1.58</td>
<td>0.002</td>
</tr>
</tbody>
</table>
# 6-Month Outcomes

<table>
<thead>
<tr>
<th>6 Month Outcomes</th>
<th>Adjusted Mean Difference</th>
<th>95% CI</th>
<th>P- Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>FACT – BMT</td>
<td>2.72</td>
<td>-2.96 to 8.39</td>
<td>0.346</td>
</tr>
<tr>
<td>FACT – Fatigue</td>
<td>0.10</td>
<td>-3.38 to 3.58</td>
<td>0.957</td>
</tr>
<tr>
<td>HADS – Depression</td>
<td>-1.21</td>
<td>-2.26 to -0.16</td>
<td>0.024</td>
</tr>
<tr>
<td>HADS – Anxiety symptoms</td>
<td>-0.61</td>
<td>-1.69 to 0.47</td>
<td>0.267</td>
</tr>
<tr>
<td>PHQ-9 – Depression</td>
<td>-1.63</td>
<td>-3.08 to -0.19</td>
<td>0.027</td>
</tr>
<tr>
<td>PCL – PTSD Symptoms</td>
<td>-4.02</td>
<td>-7.18 to -0.86</td>
<td>0.013</td>
</tr>
</tbody>
</table>
Psychological Distress at 6-Months

- **DEPRESSION (HADS)**: 10.1% (Intervention) vs 26.4% (Control), P = 0.017
- **DEPRESSION (PHQ-9)**: 14.3% (Intervention) vs 33.3% (Control), P = 0.010
- **PTSD (PCL)**: 7.3% (Intervention) vs 21.1% (Control), P = 0.002

El-Jawahri JCO 2017
Caregiver Outcomes

<table>
<thead>
<tr>
<th>2-week Caregiver Outcomes</th>
<th>Adjusted mean difference</th>
<th>95% CI</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>HADS-Depression</td>
<td>-1.65</td>
<td>-3.01 to -0.29</td>
<td>0.018</td>
</tr>
<tr>
<td>HADS-Anxiety</td>
<td>-0.14</td>
<td>-1.56 to 1.27</td>
<td>0.84</td>
</tr>
<tr>
<td>QOL</td>
<td>3.38</td>
<td>-1.59 to 8.35</td>
<td>0.180</td>
</tr>
</tbody>
</table>

Improvement in two domains of QOL

- **Coping**: adjusted mean difference = 1.01, \( P = 0.009 \)
- **Administrative/finances**: adjusted mean difference = 0.67, \( P = 0.029 \)
Initial Visit Content

- Symptoms: 88.9%
- Rapport building: 98.8%
- Coping: 85.2%
- Illness understanding: 12.3%
- Treatment decision-making: 2.5%
- Advance care planning: 2.5%
Multi-Site Randomized Trial of Integrated Palliative and Oncology Care for Patients with Acute Myeloid Leukemia (AML)

Areej El-Jawahri MD, Thomas W. LeBlanc MD, Alison Kavanaugh NP, Jason A. Webb MD, Vicki A. Jackson MD, Toby Campbell MD, Nina O’Connor MD, Selina Luger MD, Ellin Gafford MD, Jillian Gustin MD, Bhavena Bhatnagar MD, Amir Fathi MD, Gabriela Hobbs MD, Julie Foster NP, Showly Nicholson BS, Debra Davis RN BSN, Hilena Addis BS, Dagny Vaughn BA, Nora Horick MS, Joseph A. Greer PhD, Jennifer S. Temel MD
Study Design

160 patients with high-risk AML admitted to receive intensive chemotherapy

Randomization is stratified by study site, and diagnosis (newly diagnosed vs. relapsed/refractory)

Sites: MGH, Duke, Penn, Ohio State

Integrated Palliative and Oncology Care
- At least 2 visits weekly during initial and subsequent hospitalizations

Usual Care
- Palliative care consult upon request

Longitudinal Data Collection
- Patient-reported outcomes
- Health care utilization & EOL outcomes

Areej El-Jawahri MD
Patient Eligibility Criteria

• Hospitalized patients (age ≥ 18) with high-risk AML receiving intensive chemotherapy

• Exclusion criteria:
  • Patients with APML
  • Patients receiving non-intensive chemotherapy
  • Patients already receiving palliative care
  • Patients with major psychiatric or comorbid conditions

High-risk AML
1) Newly diagnosed ≥ 60 years
2) Antecedent hematologic disorder or therapy related
3) Relapsed or primary refractory AML

Areej El-Jawahri MD
Study Measures

• Patient-reported outcomes measured at baseline, weeks 2, 4, 12, and 24

• **Primary endpoint**: QOL (FACT-Leukemia) at week-2

• **Secondary endpoints**:
  
  o Psychological distress (HADS and PHQ-9)
  
  o Symptom burden (ESAS)
  
  o PTSD symptoms (PTSD Checklist- Civilian Version)
  
  o EOL outcomes:
    - Patient-reported discussions of EOL care wishes
    - Hospitalizations in the last week of life
    - Chemotherapy administration in the last 30 days of life
    - Hospice utilization

Areej El-Jawahri MD
Study Consort

Patients Assessed for Eligibility
N = 250

Enrolled and Randomized N = 160
(68.1%)

Ineligible, Not Approached N = 15
Did Not Enroll N = 75
- No interest in research (N = 23)
- Too anxious (N = 23)
- Survey burden (N = 10)
- Eligibility window elapsed (N = 10)
- Concern about costs (N = 4)
- Other (N = 5)

Usual Care N = 74

- Week-2 Assessment
  Completed N = 69 (93.2%)

- Week-24 Assessment
  Completed N = 48 (64.9%)

Integrated Palliative and Oncology Care N = 86

- Week-2 Assessment
  Completed N = 80 (90.7%)

- Week-24 Assessment
  Completed N = 57 (66.3%)

Areej El-Jawahri MD
Baseline Demographics

<table>
<thead>
<tr>
<th>Patient Characteristics</th>
<th>Usual Care (N = 74)</th>
<th>Integrated Palliative and Oncology Care (N = 86)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, median (range)</td>
<td>65.2 (22.1-80.1)</td>
<td>63.0 (19.7-77.8)</td>
</tr>
<tr>
<td>Female sex, n (%)</td>
<td>27 (36.5%)</td>
<td>37 (43.0%)</td>
</tr>
<tr>
<td>Race, n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>63 (85.1%)</td>
<td>75 (87.2%)</td>
</tr>
<tr>
<td>Black</td>
<td>7 (9.5%)</td>
<td>8 (9.4%)</td>
</tr>
<tr>
<td>American Indian</td>
<td>2 (2.7%)</td>
<td>2 (2.3%)</td>
</tr>
<tr>
<td>Asian</td>
<td>2 (2.7%)</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>1 (1.2%)</td>
</tr>
<tr>
<td>Hispanic, n (%)</td>
<td>0 (0.0%)</td>
<td>5 (6.02%)</td>
</tr>
<tr>
<td>Diagnosis type, n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newly diagnosed AML</td>
<td>50 (67.6%)</td>
<td>59 (68.6%)</td>
</tr>
<tr>
<td>Relapsed AML</td>
<td>16 (21.6%)</td>
<td>21 (24.4%)</td>
</tr>
<tr>
<td>Refractory AML</td>
<td>8 (10.8%)</td>
<td>6 (7.0%)</td>
</tr>
</tbody>
</table>
## Results

<table>
<thead>
<tr>
<th>Week-2</th>
<th>Sample size</th>
<th>Group assignment</th>
<th>Adjusted mean score</th>
<th>95% CI</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>QOL (FACT-Leukemia)</td>
<td>139</td>
<td>Usual Care</td>
<td>107.59</td>
<td>101.45 - 113.74</td>
<td>0.039</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intervention</td>
<td>116.45</td>
<td>110.69 - 122.21</td>
<td></td>
</tr>
<tr>
<td>Anxiety symptoms (HADS-A)</td>
<td>147</td>
<td>Usual Care</td>
<td>5.94</td>
<td>5.10 - 6.79</td>
<td>0.018</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intervention</td>
<td>4.53</td>
<td>3.74 - 5.34</td>
<td></td>
</tr>
<tr>
<td>Depression symptoms (HADS-D)</td>
<td>147</td>
<td>Usual Care</td>
<td>7.20</td>
<td>6.26 - 8.14</td>
<td>0.021</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intervention</td>
<td>5.68</td>
<td>4.80 - 6.56</td>
<td></td>
</tr>
<tr>
<td>Depressive syndrome (PHQ-9)</td>
<td>144</td>
<td>Usual Care</td>
<td>8.00</td>
<td>6.83 - 9.17</td>
<td>0.044</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intervention</td>
<td>6.34</td>
<td>5.23 - 7.44</td>
<td></td>
</tr>
<tr>
<td>Symptom burden (ESAS)</td>
<td>146</td>
<td>Usual Care</td>
<td>32.82</td>
<td>28.58 - 37.06</td>
<td>0.123</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intervention</td>
<td>28.24</td>
<td>24.23 - 32.25</td>
<td></td>
</tr>
<tr>
<td>PTSD symptoms (PCL- checklist)</td>
<td>146</td>
<td>Usual Care</td>
<td>31.69</td>
<td>29.56 - 33.82</td>
<td>0.009</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intervention</td>
<td>27.79</td>
<td>27.78 - 29.80</td>
<td></td>
</tr>
</tbody>
</table>

Areej El-Jawahri MD
Results

QOL

Group # Time B = 2.35
95% CI 0.02–4.68, P = 0.048

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Results

Anxiety symptoms

Group # Time B = -0.38
95% CI -0.75 – -0.01, P = 0.042

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Results

Depression symptoms

Group # Time B = -0.42
95% CI -0.82 – -0.02, P = 0.039
Results

Depression syndrome

Group # Time B = -0.21
95% CI -0.67 – 0.25, P = 0.375
Results

Symptom burden

Group # Time $B = -0.38$

95% CI $-2.09 - 1.32$, $P = 0.659$
Results

PTSD symptoms

Group # Time B = -1.43
95% CI -2.34 – -0.54, P = 0.002
Results

* 87 participants were deceased at 6-month follow up
* No difference in hospitalizations at the EOL or hospice utilization

**Patient-reported discussions of EOL care wishes**

- Usual Care: 40.0%
- Intervention: 75.0%
  - P = 0.009

**Receipt of chemotherapy in the last 30 days of life**

- Usual Care: 65.9%
- Intervention: 34.9%
  - P = 0.008

Areej El-Jawahri MD
Conclusions

Palliative care improves outcomes in hematology too, but we need more evidence
  – Novel intervention development, testing
  – Other diseases

Need for clinician education, behavior change
  – ...and primary palliative care skill development

Care model challenges remain; need for policy change
  – Transfusions, chemotherapy and hospice

Implementation and dissemination is the next big challenge to overcome!
QUESTIONS AND DISCUSSION
Lunch
Welcome back!
Palliative Care and End-of-Life Task Force Update

Tom O’Neil, MD
Palliative Care and End-of-Life Task Force

- PCEOLTF meetings
- Survey
- Palliative radiation pathways
- VitalTalk announcement
VitalTalk

- Application open June 26 – July 21, 2023
- First-come, first-served basis*
- Two options offered:
  - **Navigating Serious Conversations**
    This course is meant for professionals new to palliative care
  - **Mastering Tough Conversations**
    This course is meant for professionals working with palliative care who are looking to enhance current knowledge and skillset

*Priority will be offered to representatives from practices with limited access to palliative care
Palliative Radiation Pathways

Jennifer Griggs, MD, MPH
Palliative Radiation Collaboration
Bone Mets Working Group: Strategic Goals
MROQC

- Reduce variation in practice
- Reduce prolonged treatment courses
- Use of single fraction
- Appropriate use of technology
Bone Mets Rates of use of >10 fractions

- National Average
- MROQC (2018)
- MROQC (2020)
Development of Pathways

Workgroup formed in 2019

- Radiation oncologists
- Hospice providers
- Palliative care providers
- Patients & caregivers
Development of Pathways

• Survey of radiation oncologists in 2019
• Workgroup meetings 2019-2020
• Identification of two major clinical scenarios for patients on hospice (or considering hospice)
  • Painful bone metastases
  • Bleeding amenable to radiation therapy
• Dissemination of pathways 2022-2023
**Palliative Radiation Oncology Patients with Bone Metastases**

<table>
<thead>
<tr>
<th>SCREENING CRITERA</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy estimated to be $\geq 30$ days</td>
<td>A patient is eligible for hospice care if s/he has an estimated life expectancy of 6 months or less. Life expectancy estimations depend on several factors, including type of cancer, overall health, and the presence of comorbidities.</td>
</tr>
<tr>
<td>Palliative Performance Scale (PPS) of $\geq 40%$</td>
<td>A useful tool in prognostication is the Palliative Performance Scale (PPS, scored 0–100 in 10-point increments) in which higher numbers indicate better function. The PPS assesses five domains: 1. Ambulation (range, bed-bound to full) 2. Activity (unable to work to normal) 3. Self-care (completely dependent to completely independent) 4. Intake (mouth care only to full diet) 5. Level of consciousness (drowsy or coma to fully alert)</td>
</tr>
<tr>
<td>Localized pain (bone)</td>
<td>Localized bone pain of 3 or fewer sites with a known diagnosis of cancer.</td>
</tr>
</tbody>
</table>
# Palliative Radiation Oncology Patients with Bleeding

## SCREENING CRITERA

<table>
<thead>
<tr>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bleeding must be amenable to radiation therapy</td>
</tr>
<tr>
<td>Sites of bleeding: head and neck, bladder, chest wall/skin, gastrointestinal or gynecologic region</td>
</tr>
<tr>
<td>Patients with a history of bleeding in whom recurrent bleeding could be anticipated</td>
</tr>
<tr>
<td>Stable vital signs as assessed by hospice physician</td>
</tr>
</tbody>
</table>
Palliative Radiation Pathways

- Goals of Treatment
- Treatment Planning
- Simulation and Treatment
- Timeframe Expectations
- Recommended Preparation of Patients
- Required Documentation

Bone Metastases

Bleeding
PALLIATIVE RADIATION FOR PATIENTS ON HOSPICE: VIDEO

https://moqc.org/initiatives/clinical/palliative-radiation-therapy-pathway/
Thank you.

Submit your questions:
slido.com
#3241 511
Henry Ford Health
Center For Patient Reported
Outcomes Measures

Steven Chang, MD FACS
Samantha Tam, MD FACS
Henry Ford Health
Center for Patient Reported Outcomes

- Cancer Service Line
- Orthopedic and Sports Medicine Service Line
- Neurosciences (Neurosurgery and Neurology) Service Line
- Primary Health
- Behavioral Health
- Otolaryngology Head and Neck Surgery
How did I get here? And why PROMs?

Study Schema

**STEP 1 REGISTRATION**
Early Stage Oral Cancer Cohort (T1-3N0 AJCC 2002)

**PET/CT STUDY**
(Central Read)

**STEP 2 REGISTRATION**

**PET/CT Negative**

**STRATIFICATION**
Clinical & Radiographic T-stage (T1 vs. T3)
Pathological N-stage (N0 vs. Nx)

**RANDOMIZATION**

**ARM 1**
Stereotactic Radiosurgery (SQR) Arm

**ARM 2**
Stereotactic Radiosurgery (SQR) Arm

**PET/CT Positive**

Record necrotic pathology findings.**
Patient goes off study

---

* See Protocol Section 3.1 for details
** See Protocol Section 3.2 for details
What are patient reported outcomes (PROs)?

- Any report of the status of a patient’s health condition that comes directly from the patient, without interpretation of the patient’s response by a clinician or anyone else\(^1\)

Why should standard cancer care include patient reported quality of life?
Quality of Life Supersedes the Classic Prognosticators for Long-Term Survival in Locally Advanced Non–Small-Cell Lung Cancer: An Analysis of RTOG 9801

Benjamin Movsas, Jennifer Moughan, Linda Sarna, Corey Langer, Maria Werner-Wasik, Nicos Nicolaou, Ritsuko Komaki, Mitchell Machtay, Todd Wasserman, and Deborah Watkins Bruner

Conclusion

In this analysis, baseline global QOL score replaced known prognostic factors as the sole predictor of long-term OS for patients with locally advanced NSCLC.
Conclusions and Relevance—Despite few differences in provider-reported toxicity between arms, QOL analysis demonstrated a clinically meaningful decline in QOL on the 74Gy arm at 3 months, confirming the primary QOL hypothesis. Baseline QOL was an independent prognostic factor for survival.
Integration of PROs into the routine care of patients with metastatic cancer was associated with increased survival compared with usual care.
Why should standard cancer care include patient reported outcomes?

- Patient reported QOL is **predictive** of survival and a **better** predictor of survival than traditional indicators like stage
- Physician reported QOL is **different** and is not predictive of survival
- Real-time patient reported QOL monitoring **improved survival**
HF Cancer Patient Reported QOL

REVIEW of the Instrument

• Quality of Life domains assessed:
  – Fatigue, pain interference, physical function, depression

• NIH PROMIS CAT instrument:
  – Patient-Reported Outcomes Measurement Information Systems Computer Adaptive Test
  – Completion times range from 2-4 minutes

• All outpatient cancer visits

https://commonfund.nih.gov/promis/index
HF Cancer Patient Reported QOL
REVIEW of Clinic Workflow

Patient schedules appointment

PROMs automatically linked with appointment in EHR

EHR pushes PROMs to patient via MyChart 1 week before appointment

Severe score alerts trigger in real time in EHR

Did patient respond prior to appointment?

No

Patient checks in for appointment, CSR provides tablet for PROM completion

Scores automatically added to EHR

OncoStat alerted to severe pain interference, fatigue, and physical function scores

No

Patient checks in for appointment

Scores automatically added to EHR

LMSW alerted to severe depression scores

Yes

Patient checks in for appointment

PROMs available for provider review in EHR
Physician View in Epic
Patient Reported Quality of Life Program
2021 Accomplishments

Service Line Rollout

• Cancer Pavilion
• Hematology Oncology
• Radiation Oncology

Key Partnerships

• OncoStat
• Oncology Social Work
• Psych-Onc
• Palliative Medicine
• Cancer Pain
• Advanced Illness Management (Jackson)
• Disease team leaders

• 48 HFH Cancer Outpatient Clinics
• ~174 providers
• 9/1/20 – 8/31/22
  • # PROMs completed: 73,064
  • # patients: 12,170
  • # patients completing at >1 timepoints: 4,299
  • Method of completion MyChart: 52%; iPad: 48%
Patient Story:
Scores may correlate with need for admission

- Unresectable recurrent carcinoma of maxillary sinus on systemic treatment
- Presented to surgical clinic for routine follow up.
- PRO scores reviewed after visit by surgeon during documentation
- Scores communicated to treating medical oncologist
- Chemo treatment was withheld
- Patient was admitted and ultimately referred to Hospice
Patient Story: Additive to survivorship/surveillance

• 71yo male, T1N1M0 squamous cell carcinoma of lateral tongue treated with surgery followed by RT secondary to perineural invasion

• Cancer surveillance completed virtually; PRO completed via MyChart

• APP notified and triaged severe pain score

• Patient presented for in-person visit as result of APP triage

• Clinical examination revealed early osteoradionecrosis of mandible

<table>
<thead>
<tr>
<th>Promis Scores</th>
<th>10/2/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROMIS Pain Interference T-Score (range: 10 - 90)</td>
<td>74 (severe)</td>
</tr>
<tr>
<td>PROMIS Physical Function T-Score</td>
<td>44 (mild dysfunction)</td>
</tr>
<tr>
<td>PROMIS Depression T-Score</td>
<td>56 (mild)</td>
</tr>
<tr>
<td>PROMIS Fatigue T-Score</td>
<td>51 (within normal limits)</td>
</tr>
</tbody>
</table>
Patient Story:
Referrals to supportive oncology

• 30 yo female with metastatic breast cancer, dx 2020 at OSH
• Oncology social worker connected with patient regarding severe depression score
  – Severe depression and anxiety impacting i/ADLs; previously saw psych at OSH
  – LMSW provided brief supportive counseling, assistance with resources and home life
  – Ongoing support and monitoring plan
• Discussed with managing oncologist and care team
  – Referral to Palliative Care, referral to Psych-Onc, referral to Primary Health to establish with HF PCP
  – Referral to Cardiology – tachycardia related to anxiety

<table>
<thead>
<tr>
<th>Promis Scores</th>
<th>5/25/2022</th>
<th>5/2/2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROMIS Pain Interference T-Score</td>
<td>66 (moderate)</td>
<td>64 (moderate)</td>
</tr>
<tr>
<td>(range: 10 - 90)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROMIS Physical Function T-Score</td>
<td>38 (moderate dysfunction)</td>
<td>39 (moderate dysfunction)</td>
</tr>
<tr>
<td>PROMIS Depression T-Score</td>
<td></td>
<td>73 (severe)</td>
</tr>
<tr>
<td>PROMIS Fatigue T-Score</td>
<td>75 (severe)</td>
<td>74 (severe)</td>
</tr>
</tbody>
</table>
Next Steps, Next Questions...

- What did we learn from the implementation?
- What do I do with the scores?
- How do I interpret the scores?
- Who is going to act on the scores?
- How useful/additive is the program?
- What is the impact on clinic workflow?
- How can we improve upon the program?
- Can we leverage this work for research?
- Is the program able to predict survival for patients?
- Is the program able to improve overall survival for patients?
Patient Reported Quality of Life Program 2022

Key partnerships
Provider, CSR, and patient surveys + semi-structured interviews

PRO score analysis (severity, changes, frequency)

Completion rates

Guidance to clinical providers (MD, APP, RN, MA)

Patient Research Experience
Patient Reported Quality of Life Program

Pillars

**Operations**
- PROs in clinical care operations across the cancer care continuum
- Part of patient care experience and an additive data point in clinical decision-making for staff

**Disease outcomes**
- Leverage PROs to better understand predictors and drivers of outcomes like survival, quality of life, and cost
- and through that understanding, improve health outcomes.

**Equity**
- Leverage PROs as a tool to improve health equity
- Ensure equity in PRO implementation, adoption, and PRO-based interventions

**Value**
- Demonstrate the ROI/value of PRO integration in standard cancer care through multi-level value assessment

Research
- PRO research priorities and resourcing are aligned with Cancer PRO initiatives, investment, and decision-making. There is a continuous feedback loop between research and the other PRO pillars.

Patient Experience

**Data:** should be accessible, usable, and additive for clinical, quality, and research questions

**Analyses:** the questions we are trying to answer for improvement

**Partnerships:** OncoStat, Palliative Medicine & AIM, Cancer Pain, Psych-Onc, Social Work, Disease Teams, Primary Care, PHS
Research and Operations
HF Cancer Preliminary Findings

Analysis performed in partnership with PHS Biostatistics Team and programming support: Laila Poisson, Kylie Springer, Carl Wilson, Samantha Tam, Eric Adjei Boakye, Md Sakibur Hasan, Mohammed Baseer, Wan-Ting Su, Smitha Jogunoori, Alla Sikorski, Peter Watson, Charlie Bloom
The Highlights...

• Analysis showed how important PRO-QOL is to patient care
  – Patient reported quality life worsens as they approach death
  – As patients approach death, the number of domains that fall into the severe range increases
  – Patient reported quality of life may be predictive of overall survival of cancer patients
  – Patient reported quality of life is predictive of health care utilization
  – Patient reported quality of life needs to be taken in the context of all clinically available data

• Implementation did not impact clinical workflows
  – Physician opinions of the PRO QOL program implementation were neutral to positive
  – Patients are more likely to complete the instruments if they know clinicians are utilizing them
  – Guidance on what to do with the scores were developed and implemented

• Research has been infused into this work from the start
  – Several Grants, Papers and Abstracts are being generated based on this work
Increasing fatigue and pain interference within the last 3 months prior to death

Fatigue

Pain Interference

PRO Score

Months prior Death

PRO Score

Months prior Death
Decreasing physical function within the last 3 months prior to death
Decreasing physical function prior to death
What about in a case-control?

- After matching, there is a significant mean change for cases vs controls for each domain in the 6 months before death

<table>
<thead>
<tr>
<th>Domain</th>
<th>Mean Change Cases vs Controls</th>
<th>95% lower CI</th>
<th>95% upper CI</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatigue (n=1487)</td>
<td>6.36</td>
<td>5.01</td>
<td>7.71</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Physical Function (n=1509)</td>
<td>-8.59</td>
<td>-9.81</td>
<td>-7.38</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Pain Interference (n=1569)</td>
<td>5.55</td>
<td>4.26</td>
<td>6.84</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Depression (n=1705)</td>
<td>3.89</td>
<td>2.75</td>
<td>5.04</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

- A nested case-control study design with replacement was used.
- Cases: patients that died (N=526) within 6 months of taking at least one PROM.
- Controls: patients that were alive and being followed at the time of the case’s death.
  - Matched 3:1 to cases by age (within 5 years) at the earliest PROM, sex, cancer type, and cancer stage.
Increasing proportion of patients with severe scores within the last months prior to death
• After controlling for age, sex, and comorbidity, pain, fatigue, and physical function (one PRO at a time) were significant predictors of hospitalizations in the next 30 days. Depression was not.
• When all 4 PRO scores were included as predictors along with age, sex, and comorbidity, significant predictors were: younger age, male sex, greater comorbidity, and poorer physical function: OR=0.97, 95% CI (0.94, 0.99), p<.01 per unit of increase in score.

Through HFH-MSU Pilot Grant: analysis performed by MSU partner – Alla Sikorskii with HAP claims data
PRO QOL predicts ED/Urgent care
Pain interference is most predictive

- After controlling for age, sex, and comorbidity, pain and physical function (one PRO at a time) were significant predictors of ED/urgent care use in the next 30 days, Depression and fatigue were not.
- When all 4 PRO scores were included as predictors along with age, sex, and comorbidity, significant predictors were: younger age, male sex, greater comorbidity, and greater pain interference: OR=1.05, 95% CI (1.02, 1.09), p<.01 per unit of PROMIS score.
The unadjusted analyses of PRO measures in relation to hospitalizations and ED/urgent care visits in the subsequent 30 days:

- When considered one at a time, pain, fatigue, and physical function are significant predictors of both events. Depression is not predictive.
- When entered as simultaneous multiple predictors, physical function wins over other predictors in its association with future hospitalizations.
- For the ED/urgent care, key predictor is pain over the other PROs

• Analysis performed with HAP claims data, which ensures most complete capture of health care utilization
For ED/urgent care, key predictor is pain over the other PROs

<table>
<thead>
<tr>
<th>PRO</th>
<th>ED/urgent care visit in the next 14 days</th>
<th>ED/urgent care visit in the next 30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR</td>
<td>95% CI</td>
</tr>
<tr>
<td>Pain interference</td>
<td>1.06</td>
<td>(1.03, 1.09)</td>
</tr>
<tr>
<td>Physical function</td>
<td>0.97</td>
<td>(0.94, 0.99)</td>
</tr>
<tr>
<td>Fatigue</td>
<td>1.02</td>
<td>(0.99, 1.05)</td>
</tr>
<tr>
<td>Depression</td>
<td>1.01</td>
<td>(0.98, 1.04)</td>
</tr>
</tbody>
</table>

Table 2. The effect of per unit increase in PROs on ED/urgent care visits in the next 14 and 30 days, adjusted for age at first PRO assessment, sex, comorbidity, advanced cancer, median household income and high school education in the Census tract.

Note: Controlling for site of cancer does not change these results in an appreciable way.
Cutpoints for 30-day ED/UC visits:
Significant interaction of pain interference ≥60 & physical function of ≤45 with advanced cancer

<table>
<thead>
<tr>
<th>Pain Interfer. cut-off</th>
<th>Advanced cancer</th>
<th>Non-advanced cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ROC area (95% CI)</td>
<td>OR (95% CI)</td>
</tr>
<tr>
<td>50</td>
<td>.73 (0.96, 6.50)</td>
<td>2.45 (.06</td>
</tr>
<tr>
<td>55</td>
<td>.73 (1.01, 5.21)</td>
<td>2.29 (.048</td>
</tr>
<tr>
<td>60</td>
<td>.76 (1.47, 7.31)</td>
<td>3.38 (.003</td>
</tr>
<tr>
<td>65</td>
<td>.74 (0.94, 7.72)</td>
<td>2.51 (.07</td>
</tr>
<tr>
<td>70</td>
<td>.70 (0.12, 7.02)</td>
<td>0.91 (.93</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical function cut-off</th>
<th>Advanced cancer</th>
<th>Non-advanced cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ROC area (95% CI)</td>
<td>OR (95% CI)</td>
</tr>
<tr>
<td>50</td>
<td>.73 (0.96, 6.50)</td>
<td>0.39 (0.12, 1.34)</td>
</tr>
<tr>
<td>45</td>
<td>.76 (1.01, 5.21)</td>
<td>0.25 (0.08, 0.76)</td>
</tr>
<tr>
<td>40</td>
<td>.75 (1.47, 7.31)</td>
<td>0.36 (0.15, 0.85)</td>
</tr>
<tr>
<td>35</td>
<td>.72 (0.94, 7.72)</td>
<td>0.50 (0.19, 1.32)</td>
</tr>
<tr>
<td>30</td>
<td>.72 (0.12, 7.02)</td>
<td>3.34 (0.39, 28.84)</td>
</tr>
</tbody>
</table>

Table 3. ORs for various cut-points for PRO cut-offs in relation to 30-day ED/UC visits by advanced cancer, adjusted for age at first PRO assessment, sex, comorbidity, median household income and high school education in the Census tract.

Through HFH-MSU Pilot Grant: analysis performed by MSU partner – Alla Sikorskii with HAP claims data.
Cutpoints for **14-day** ED/UC visits:
Significant interaction of pain interference ≥60 & physical function of ≤45 with advanced cancer

<table>
<thead>
<tr>
<th>Advanced cancer</th>
<th>Non-advanced cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pain interfer. ROC area</strong></td>
<td><strong>(95% CI)</strong></td>
</tr>
<tr>
<td><strong>cut-off</strong> 50</td>
<td>.72</td>
</tr>
<tr>
<td>55</td>
<td>.70</td>
</tr>
<tr>
<td>60</td>
<td>.76</td>
</tr>
<tr>
<td>65</td>
<td>.70</td>
</tr>
<tr>
<td>70</td>
<td>.67</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Advanced cancer</th>
<th>Non-advanced cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical function ROC area</strong></td>
<td><strong>(95% CI)</strong></td>
</tr>
<tr>
<td><strong>cut-off</strong> 50</td>
<td>.70</td>
</tr>
<tr>
<td>45</td>
<td>.72</td>
</tr>
<tr>
<td>40</td>
<td>.73</td>
</tr>
<tr>
<td>35</td>
<td>.68</td>
</tr>
<tr>
<td>30</td>
<td>Did not converge</td>
</tr>
</tbody>
</table>

Table 4. ORs for various cut-points for PRO cut-offs in relation to 14-day ED/UC visits by advanced cancer, adjusted for age at first PRO assessment, sex, comorbidity, median household income and high school education in the Census tract.
Which domains were most commonly seen together?

*Pain interference, fatigue and physical function are correlated*
Summary

• Patient reported quality life worsens as they approach death
• As patients approach death, the number of domains that fall into the severe range increases
• Patient reported quality of life may be predictive of overall survival of cancer patients
• Patient reported quality of life is predictive of health care utilization
• Patient reported quality of life needs to be taken in the context of all clinically available data
Physician/Clinical Staff Perspectives
Assessment of Implementation

• Assessments Completed
  – Surveys to physicians and APPs
  – Surveys to CSRs

• Assessments Underway
  – Surveys to patients (responders and non-responders)
  – Interviews
    • Physicians, CSRs and patients (responders and non-responders)

Through HFH-MSU Pilot Grant: MSU partner – Kelly Hirko
Manuscript in process. Will be used as part of PRO Health Equity R01 Submission
How useful/additive is the program? What is the impact on clinic workflow?

*Provider* opinions of the PRO implementation were neutral to positive

- The majority of providers review PROs when available
- The majority of providers find PROs beneficial & influence their clinical care
- Physicians seek more consistent availability of scores
- Physicians would like more guidance on what to do with the scores
How useful/additive is the program? What is the impact on clinic workflow?

- The majority of CSRs found the tablet training and number of tablets to be adequate
- The majority of CSRs experience patients declining to complete PROMs at check-in
  - Patients don’t know if the instruments are being integrated into their care
    - → Increase communication and integration in clinic visits
    - → Provider education and utilization in clinics
  - Patients don’t feel well at check in
    - → Encourage completion via MyChart through Echeck-in (upstream)
    - → Future workflow for MAs to facilitate completion if not done (downstream)

Through HFH-MSU Pilot Grant: MSU partner – Kelly Hirko
PRO/MA Rooming Process – BHCP 2023
Integrate PROs into MA rooming protocol

1. Patients can complete PROMs on MyChart or iPad at appointment check-in
   - Fatigue, pain, physical function: q2w
   - Depression: q1m

2. MA will check for scores in Epic & will alert provider to any severe scores, similar to notification for abnormal vital signs
   - MAs will NOT be helping patients to complete PROs in the room at this time; completion will remain via MyChart or on the iPad at appointment check-in
Updated Workflow

Patient schedules appointment

EHR pushes PROMs to patient via MyChart 1 week before appointment

Did patient respond prior to appointment?

Yes

Patient checks in for appointment

Scores automatically added to EHR

PROMs available for provider review in EHR

No

OncoStat alerted to severe scores

LMSW alerted to severe depression scores

LMSW contacts patient by phone or at in-person visit

LMSW provides brief supportive counseling, assesses for safety and support, escalates to Psych-Onc as needed

LMSW documents in EHR; routes note to Psych-Onc provider if patient already follows with Psych-Onc

MA reviews PROs during roaming

Severe scores?

Yes

MA verbal handoff to provider about severe scores

Clinical decision support for severe PI, fatigue

Severe score alerts trigger in real time if completed prior to appointment

Severe score alerts trigger in real time if completed prior to appointment

Severe score alerts trigger in real time if completed prior to appointment
Guidance for Patients with Severe Pain Interference Scores

Severe pain score

- Pain related to cancer?
  - Yes → Severe Physical Function Score?
    - Yes → Referral to Palliative Medicine
    - No → Stage IV Disease?
      - Yes → Referral to Cancer Pain Service
      - No → Referral to General Pain Service
  - No → Referral to General Pain Service
Guidance for Patients with Severe Fatigue

Are there other severe PRO scores?

Stage 4?

Should the tx plan be amended?

Are labs available for review?

OncoStat visit for assessment and/or labs

Begin workup. If non-HFMC PCP, refer directly instead of initiating workup.

OncoStat visit for assessment and/or labs

Have you ruled out causes associated with the cancer type or tx?

Yes

Referral to HFMC PCP

To be defined with Primary Care: what type of hand off should occur? What should be included when sending patients to Primary Care/back to Cancer?

No

Severe Pain Interference (Pain Referral Grid)

Severe Depression (LMSW follow-up)

Referral to Palliative Medicine

Refer back to Medical Oncology (or treating oncologist)
## Cancer-related fatigue: Initial diagnostic workup

<table>
<thead>
<tr>
<th>Test</th>
<th>Treatable contributing factor</th>
<th>Examples of possible diagnostic evaluation*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electrolytes (sodium, potassium, chloride, bicarbonate)</td>
<td>Cardiac dysfunction (eg, arrhythmia, hypertension, coronary artery disease, heart failure)</td>
<td>Consider echocardiogram, exercise test for cardiopulmonary reserve</td>
</tr>
<tr>
<td>Chemistry panel (creatinine, blood urea nitrogen, glucose, magnesium, calcium, phosphorus, total bilirubin, serum transaminases, alkaline phosphatase, lactic dehydrogenase, albumin, total protein)</td>
<td>Endocrine dysfunction (eg, diabetes, hypothyroidism, hypogonadism, adrenal insufficiency)</td>
<td>Consider measuring HgbA1C, TSH, glucose, and testosterone, conduct dexamethasone suppression test</td>
</tr>
<tr>
<td>Thyroid-stimulating hormone (TSH)</td>
<td>Pulmonary dysfunction</td>
<td>Consider chest x-ray, six-minute walk test, pulmonary function tests, oxygen saturation</td>
</tr>
<tr>
<td>Complete blood count (CBC) with differential and platelet count</td>
<td>Renal dysfunction</td>
<td>Consider kidney and electrolyte chemistries</td>
</tr>
<tr>
<td>Serum testosterone, in men if clinical history suggestive of hypogonadism</td>
<td>Anemia</td>
<td>Consider CBC</td>
</tr>
<tr>
<td></td>
<td>Arthritis</td>
<td>Consider erythrocyte sedimentation rate (ESR), serologies</td>
</tr>
<tr>
<td></td>
<td>Neuromuscular complications (neuromuscular degenerative disease, neuropathy)</td>
<td>Consider grip strength test, neuropathy sensory testing, electromyography</td>
</tr>
<tr>
<td></td>
<td>Sleep disturbances (eg, insomnia, sleep apnea, vasomotor symptoms, restless leg syndrome)</td>
<td>Consider assessing sleep with standardized questionnaire, possible sleep study</td>
</tr>
<tr>
<td></td>
<td>Pain</td>
<td>Evaluate with standardized assessment tool</td>
</tr>
<tr>
<td></td>
<td>Emotional distress (eg, anxiety, depression)</td>
<td>Evaluate with standardized assessment tool or diagnostic interview</td>
</tr>
</tbody>
</table>


NOTE: This list is not meant to be exhaustive.

CBC: complete blood cell count; HgbA1C: hemoglobin A1C; TSH: thyroid-stimulating hormone.
* Should be undertaken only when clinically appropriate.

Who is completing PROs?
Defining “completing”

\[
\text{Completion rate} = \frac{\text{number of completed PROs}}{\text{number of offered PROs}}
\]
Completion Rate by Specialty Divisions (top 5 most Frequent)

Radiation Oncology and Otolaryngology tend to have higher completion rates on average.
Specialty Division, Race, and Location are predictors of PROM Completion

Through **HFH-MSU Pilot Grant: MSU partner – Kelly Hirko**

*Appeared in model and top 3 in variable importance table
*Appeared in model
A Closer Look at Completion for Specialty Division & Race

Percentage of Completion by Race and Specialty Division

<table>
<thead>
<tr>
<th>Specialty Division</th>
<th>White</th>
<th>Black</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>32.40%</td>
<td>22.82%</td>
<td>28.31%</td>
</tr>
<tr>
<td>Rad Onc</td>
<td>44.57%</td>
<td>36.26%</td>
<td>37.04%</td>
</tr>
<tr>
<td>Supportive Oncology</td>
<td>37.25%</td>
<td>6.67%</td>
<td>42.86%</td>
</tr>
<tr>
<td>Surgery</td>
<td>46.46%</td>
<td>29.82%</td>
<td>31.82%</td>
</tr>
</tbody>
</table>

Through HFH-MSU Pilot Grant: MSU partner – Kelly Hirko
A Closer Look at Completion for Specialty Division & Race

Percentage of Completion by Race and Specialty Division

<table>
<thead>
<tr>
<th>Specialty Division</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>34.33%</td>
</tr>
<tr>
<td>Rad Onc</td>
<td>46.67%</td>
</tr>
<tr>
<td>Supportive Oncology</td>
<td>38.00%</td>
</tr>
<tr>
<td>Surgery</td>
<td>47.66%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Survey Status</th>
<th>Specialty Division</th>
<th>Race</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
<td>Black</td>
</tr>
<tr>
<td>Completed</td>
<td>Medicine</td>
<td>34.33%</td>
</tr>
<tr>
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<td></td>
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<td>47.66%</td>
</tr>
</tbody>
</table>

Through HFH-MSU Pilot Grant: MSU partner – Kelly Hirko
Thank you!

Questions?
Patient Reported Outcomes (PROs)
The PROs Team

Chris Friese, PhD, RN  
Director, Patient-Reported Outcomes

Shayna Weiner, MPH  
Project Manager

Ashley Bowen, MS, RD  
Project Manager

Robin Voisine  
MSW Intern
Why are we collecting PROs?

- Shown to increase survival for oncology patients
- Helps focus clinical interventions
- Prioritizes MOQC improvement efforts
- Centers on patient & family needs
- Collecting PROs will be part of MOQC Certification
Who are we collecting PROs from?

• Adults w/ invasive cancer receiving anti-cancer therapy
• Includes IV, SC, Oral, and Maintenance therapy
• **Very inclusive.** When in doubt, offer to patient!
What information are we collecting?

• Survey asks about symptoms, social needs, demographics
• Patient can opt-in to provide identification to link with clinical data in MOQCLink
• Results are not seen by care team in real time
A reminder that your results are not shared with your care team. Please discuss your experience with your nurse or doctor.

As people go through treatment for their cancer, they sometimes experience different symptoms and side effects. For each question, please select the one answer that best describes your experiences over the last seven days.

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the last 7 days, how often did you have NAUSEA?</td>
<td>Never, Rarely, Occasionally, Frequently, Almost constantly</td>
</tr>
<tr>
<td>In the last 7 days, how often did you have VOMITING?</td>
<td>Never, Rarely, Occasionally, Frequently, Almost constantly</td>
</tr>
<tr>
<td>In the last 7 days, what was the severity of your CONSTIPATION at its WORST?</td>
<td>None, Mild, Moderate, Severe, Very severe</td>
</tr>
<tr>
<td>In the last 7 days, how often did you have LOOSE or WATERY STOOLS (DIARRHEA)?</td>
<td>Never, Rarely, Occasionally, Frequently, Almost constantly</td>
</tr>
<tr>
<td>In the last 7 days, what was the severity of your NUMBNESS or TINGLING in your HANDS/FEET at its WORST?</td>
<td>None, Mild, Moderate, Severe, Very severe</td>
</tr>
<tr>
<td>In the last 7 days, how often did you feel ANXIETY?</td>
<td>Never, Rarely, Occasionally, Frequently, Almost constantly</td>
</tr>
<tr>
<td>In the last 7 days, how often did you have SAD OR UNHAPPY FEELINGS?</td>
<td>Never, Rarely, Occasionally, Frequently, Almost constantly</td>
</tr>
</tbody>
</table>
Sometimes, patients have other concerns during their cancer treatment. We would like to know more about this so we can offer better services to patients in the future.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>In the last 12 months, has the electric, gas, oil, or water company threatened to shut off your services in your home?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are you worried that in the next 2 months, you may not have stable housing?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do problems getting child care make it difficult for you to work or study?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>In the last 12 months, have you needed to see a doctor, but could not because of cost?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do you ever need help reading handouts from your doctor's office or hospital?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do you often feel that you lack companionship?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are any of your needs urgent?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If you checked YES to any boxes above, would you like help with any of these needs?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

We do not share your results with your cancer care team. If you need help with any of the things listed above, please speak to someone in the office today.
How are we collecting PROs?

• Data collection for 2 weeks (10 clinic days)
• MOQC-provided tablets for PRO collection, paper backup
  – All tablets have both a data plan and Wi-Fi capabilities
• Brief script provided to explain the project to patients
When are we collecting PROs?

• 3 Pilot Sites Summer 2023
  – Munson Healthcare Cowell Family Cancer Center
  – Sparrow Herbert-Herman Cancer Center
  – Hematology Oncology Consultants

• 10 Additional Sites Fall/Winter 2023
  – Oncology Hematology Associates of Saginaw Valley
  – MyMichigan Health
  – KCI at McLaren Bay Region
  – ...so far!

• Remaining MOQC sites Winter/Spring 2024
Onboarding Process Overview

• Informational meeting
• Dates reviewed and confirmed
• Virtual training set for clinic/infusion staff
• MOQC team available for support throughout
Thank you to our task force members!

- Megan Beaudrie
- Tracey Cargill-Smith
- Diane Drago
- Jacklyn Griffin
- Mike Harrison
- Amanda Itliiong
- Pat Keigher

- Kathy LaRaia
- Cindy Michelin
- Lindsey Ranstadler
- Jerome Seid
- Dawn Severson
- Patrice Tims
Please check out the PROs test site and tablets at the MOQC resources table!

Contact us to set up your dates for collection!
Break
Palliative Care Access & Referral Patterns: A Tale of Two Surveys

Andrew Russell, MD/MPH
Integrated Fellow in Geriatric & Palliative Medicine
University of Michigan
June 16, 2023
Objectives

1. Describe the current landscape of access to clinic-based palliative care based on survey results
2. Describe how oncology practices in Michigan utilize referrals to palliative care clinics
2 separate surveys

<table>
<thead>
<tr>
<th>Survey</th>
<th>Study sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1: Clinic-based palliative care (CBPC) survey</td>
<td>Palliative care clinics</td>
</tr>
<tr>
<td>#2: MOQC expanded palliative care survey</td>
<td>MOQC member practices</td>
</tr>
</tbody>
</table>
Survey #1: Clinic-based palliative care (CBPC) survey

• **Background:**
  • Healthcare organizations are expanding access to palliative care (PC) by opening outpatient clinics
  • Little is known about the density & characteristics of clinic-based palliative care (CBPC) services in MI

• **Study aims:**
  1. To describe the *density* of CBPC services across MI based on region
  2. To describe the *content* of CBPC services in MI
CBPC survey: Methods

- Online survey assessed the prevalence of CBPC clinics
- PC programs were identified by:
  - Interviewing key informants
  - Internet searches
  - National Hospice and Palliative Care Organization online directory
  - Hospice and Palliative Medicine discussion boards
  - Snowball sampling from both CBPC and MOQC surveys
- Excluded home health/hospice agencies
- Survey sent to clinical/administrative directors
- Questions asked about clinic characteristics
- Indexed to calendar year 2021
- Responses were gathered from June 2022-Apr 2023
CBPC survey: Results

• 17 non-home health PC programs identified, of which...
  • **16** programs had CBPC programs, with a total of...
    • **33** individual clinics

• Programs include:
  • Ascension Borgess
  • Ascension Genesys
  • Ascension St. John
  • Centracare (Bronson Health)
  • Children’s Hospital of Michigan
  • Corewell Health (formerly Spectrum Health)
  • DeVos Children’s Hospital
  • Henry Ford Health

• Karmanos
• Michigan Medicine
• Munson Healthcare
• MyMichigan
• Trillium (Holland Home)
• Trinity IHA
• Trinity Saint Mary’s
• University of Michigan-West
CBPC survey: Clinic characteristics (N=33)

<table>
<thead>
<tr>
<th>Category</th>
<th>n (%)</th>
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</thead>
<tbody>
<tr>
<td>Academic-affiliated</td>
<td>6 (18.2%)</td>
</tr>
<tr>
<td>Cancer-only diagnosis accepted</td>
<td>13 (40.6%)</td>
</tr>
<tr>
<td>Accepts pts from outside health system</td>
<td>24 (77.4%)</td>
</tr>
<tr>
<td>Accepts non-English speakers</td>
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<tr>
<td>Covers outside office hours</td>
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<td>Accepts pts &lt;18yo</td>
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<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td># New-patient visits per year</td>
<td>118.9 (6-477)</td>
</tr>
<tr>
<td># Follow-up visits per year</td>
<td>304.7 (25-2000)</td>
</tr>
<tr>
<td>Wait time (in weeks)</td>
<td>1.8 (1-8)</td>
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<tr>
<td>% No-shows for new-pt visits</td>
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CBPC survey: Clinic location & size

[Map of Michigan showing clinic locations with various markers and sizes indicating the number of patients seen.]
Clinic density in MI
Clinic density in MI
CBPC survey: Clinic capacity

Mean = 3.1 half-days per week (range 1-10)
CBPC survey: Conclusions

• CBPC programs in MI are **few** and **clustered in densely populated areas**
  • Many rural communities do not have access to a physical clinic
  • 40% of CBPC is delivered via **telehealth**, suggesting an avenue through which care may be provided to remote areas

• 40% of clinics do not see **non-cancer** patients
  • May be hard for cancer patients to access PC once they’re in remission

• Characteristics **vary widely** between programs
  • Providers should not assume all programs offer:
    • At least one physician on staff
    • Pediatric palliative care
    • Telehealth
Survey #2: MOQC expanded PC survey

• **Survey aims:**
  • To assess how oncology practices in MI utilize referrals to PC clinics
  • To explore barriers oncology practices face in PC access, as well as possible avenues around these barriers

• **Methods:**
  • Online survey
  • Distributed via email to practice manager for each MOQC practice beginning Jan 2023
  • Distributed on paper at regional meetings in Mar-Apr 2023
MOQC PC survey: Results

• Study population:
  • 55 MOQC member practices

• Response rate:
  • 56% as of May 2023
  • 31 total respondents

• Characteristics:
  • 26 Heme-Onc practices; 5 Gyn-Onc practices
  • 55% have neither a co-located PC clinic nor embedded PC (i.e., who shares the same space & co-manages patients)
MOQC PC survey: Co-located or embedded PC

- 55% Co-located PC clinic
- 32% Embedded PC
- 13% No access to PC w/in health system or group practice
MOQC PC survey: Practice patterns

- Referrals to PC clinics:
  - # PC clinics referred to: mean 1.9 (range 0-4)
  - Reasons for referral:
    1. Advanced care planning and/or goals of care
    2. Acute/chronic pain
    3. Home care needs
    4. Non-pain symptoms
    5. Mental health

- **79%** of practices refer to *home-based PC*
MOQC PC survey: Barriers

- Availability/access to providers
- Patient knowledge/perceptions
- Geography/transportation
- Insurance coverage
- Lack of communication/collaboration
- Technology
- Burdensome for patients
• 43% would NOT utilize PC e-consults

• Reasons for not utilizing e-consults include:
  • Already having embedded PC (most common)
  • Patients/providers preferring face-to-face visits or home-based PC
  • Lack of staffing support
  • Provider concerns about “lack of integration”
MOQC PC survey: Conclusions

• Most MOQC practices have no access to PC w/in their health system or group practice

• Wide geographic disparities exist in access to PC clinics

• Despite this, 43% of MOQC practices would not use e-consults
What are other ways we can improve access to palliative care?

1) **Telehealth**
   Issues include:
   - Compatibility across EHRs
   - Credentialing across health systems
   - Developing payment structures
   - Not all patients have adequate internet bandwidth, access to computers, or tech literacy

2) **Home-based PC**
   Issues include:
   - Poor communication back to oncologist
   - Only see patients <2x/mo
   - Many will not prescribe opioids
Plan to survey home-based PC programs
  • Map their geographic access across the state
  • Describe their operating procedures
Thank you!

Contact:
Andy Russell, MD/MPH
University of Michigan
russeand@med.umich.edu
Responding to Patient Needs – Embedding Pharmacists in Oncology Practices with POEM

Katie Sias, PharmD, BCOP
MyMichigan Health – Mt. Pleasant, Midland, Alpena, Alma, Gladwin

Mark Wagner, PharmD, BCOP
Munson Healthcare – Traverse City, Cadillac, Charlevoix, Gaylord, Grayling, Manistee

Emily Mackler, PharmD, BCOP
POEM Director

MICMT (MI Institute for Care Management and Transformation) and MOQC (MI Oncology Quality Consortium)
Objectives

Summarize characteristics of the Pharmacists Optimizing Oncology Care Excellence in Michigan (POEM) program

Describe the POEM pharmacists’ experience in integrating into community oncology sites

Review outcomes of the POEM program to date
POEM Information

• Collaboration between MICMT and MOQC
• Integration of clinical oncology pharmacists in direct patient care → improve patient care and outcomes
• Based on prior success with the Michigan Pharmacists Transforming Care and Quality (MPTCQ) model of integrating pharmacists in primary care
• Clinical focus areas:
  • Oral anticancer agents (OAAs)
  • Immunotherapy
  • Symptom management and optimization
  • Patients with multiple co-morbidities
  • High risk disease states
POEM Support

Pharmacist:
• Billing support/guidance
• CPA* support/guidance
• Weekly touch bases and peer collaboration
• Patient advocate involvement
• Data analysis
• Oncology-based education
• Outcome dissemination
• Annual retreat

Practice/Physician Organization:
• Pharmacist salary
  • 100% year 1
  • 60% year 2
  • 20% year 3
• Value-based reimbursement
  • 10% on all BCBSM E/M codes→ 15% March 2023
• Quarterly reports
• Abstraction support
• Data analysis
• Billing support/guidance

*CPA = Collaborative Practice Agreement
Launched October 2020

- 6 Clinical Oncology Pharmacists
- 8 Physician Organizations
- 24 Oncology Sites
- 72 Physicians
- 4171 Patients*
- 12417 Encounters
- 10471 Interventions

*Data up to 3/31/23
Program Growth

• 2022: 4 new pharmacists/sites committed
  • Contracts all signed
  • 1 pharmacist started in Fall 2022 (Munson, 2nd POEM pharmacist)
  • 1 pharmacist started in Spring 2023 (Sparrow Herbert-Herman Cancer Center)
  • Remaining 3 sites anticipate Summer 2023 starts
    • Corewell Health (Spectrum Health), Grand Rapids
    • Covenant HealthCare, Saginaw
    • The Cancer and Hematology Centers, Grand Rapids, Holland, Norton Shores
• 2023: We’re still recruiting! Please let us know if interested.
Objectives

- Summarize characteristics of the Pharmacists Optimizing Oncology Care Excellence in Michigan (POEM) program
- Describe the POEM pharmacists’ experience in integrating into community oncology sites
- Review outcomes of the POEM program to date
## Cohort 1

<table>
<thead>
<tr>
<th>Pharmacist Clinical Focus</th>
<th>Start Date</th>
<th>1st RedCap Encounter</th>
<th>CPA Approval Date</th>
<th>Care Mngmt Billing before POEM</th>
<th>Care Mngmt Billing post POEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>EJ OAAs + Comorbidities</td>
<td>10/12/20</td>
<td>11/13/20</td>
<td>12/2020</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>CM Immunotherapy</td>
<td>11/1/20</td>
<td>3/30/21</td>
<td>Pending</td>
<td>Yes – only RN, SW</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*CPA = Collaborative Practice Agreement*
## Cohort 2

<table>
<thead>
<tr>
<th>Pharmacist Clinical Focus</th>
<th>Start Date</th>
<th>1st RedCap Encounter</th>
<th>CPA Approval Date</th>
<th>Care Mngmt Billing before POEM</th>
<th>Care Mngmt Billing post POEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>KS OAAs + High Risk</td>
<td>3/8/21</td>
<td>4/21/21</td>
<td>4/2021</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>MW Symptoms/PROs → OAAs</td>
<td>7/5/21</td>
<td>7/26/21</td>
<td>8/2021</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>JG OAAs</td>
<td>8/30/21</td>
<td>10/21/21</td>
<td>9/2022</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>OY OAAs</td>
<td>10/5/21</td>
<td>3/2022</td>
<td>3/2022</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*CPA = Collaborative Practice Agreement
Most Common Medication Interventions

• Optimizing antiemetic use
• Constipation management
  • Antiemetic side effect
  • Opioid use and no prophylaxis
• Gastrointestinal symptom management – diarrhea and nausea
• Complimentary and Alternative Medicine (CAM) and other drug interactions
Team Accolades

• BCOP (Board Certified Oncology Pharmacist) – passed 1 year post POEM engagement
• Multiple CE talks for the State via MICMT and MOQC
• American Society of Clinical Oncology (ASCO) Quality Care Symposium Poster – Fall 2021 and Fall 2022
• MOQC Annual Meeting Presentation – January 2022
• Hematology/Oncology Pharmacy Association (HOPA) Annual Conference Presentations
  • April 2022 Collaborative Practice Agreements
  • April 2023 Platform Research Presentation on Immune Checkpoint Inhibitor Management
• MSHO Oncology Pharmacists Forum – May 2022 and 2023
• Podcast – May 2023
Learning Objectives

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Outcome Assessment

• Pharmacist report – RedCap
  • Patient demographics
  • Encounters
  • Interventions
• Patient satisfaction
• Physician satisfaction
• Care management billing optimization
• Abstracted pre- and post-outcomes
• Reimbursement for services and program participation
Data – Demographics

- Female: 49%
- White: 92%, Black: 5%
- 12% of patients live in small towns or rural areas
- 25% of patients live in a zip code where the mean household income is <$35,000/year (cancer treatments - $10,000 - $20,000/month)
Data – Outcomes

• Encounters
  • 100 encounters/week over the last year
  • 97 encounters/week over the past quarter
  • 67% of encounters billed a care management code

• Interventions
  • Include comprehensive medication reviews or medication reconciliation, coordination or escalation of care, education, and medication modifications
  • 116 interventions/week over the last year
  • 123 interventions/week over the past quarter
Data – Interventions

Data up to 3/31/23
Data – Medication Modifications

Data over the last year 4/22 – 3/23

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Number of Interventions</th>
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<tbody>
<tr>
<td>Adjust Dose</td>
<td>120</td>
</tr>
<tr>
<td>Adjust Interval</td>
<td>39</td>
</tr>
<tr>
<td>Change Medication</td>
<td>70</td>
</tr>
<tr>
<td>Start Medication</td>
<td>120</td>
</tr>
<tr>
<td>Stop Medication</td>
<td>96</td>
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Reason for Intervention
- Cancer treatment
- Comorbidity management
- Comprehensive medication review
- Symptom management
- Cancer Diagnosis
- Medication access
- Other
- Medication Reconciliation
Data – Care Coordination

**Coordination of Care**
- Communication with provider regarding plan of care: 480
- Ordered lab monitoring: 250
- Communication with specialty pharmacy: 225
- Communication with staff regarding scheduling a follow up visit: 146

**Escalation of Care**
- Oncologist: 30
- Emergency department: 10
- Other: 8
- Oncology NP/PA: 6
- Urgent care: 4
- Same-day cancer acute care: 2

**Referral Made**
- Primary Care Physician: 27
- Other Oncology Specialty Physician: 24
- Social Work: 22
- Dietician: 19
- Non-Oncology Specialty Physician: 14
- Palliative Care Team: 8
- Pharmacist (Non-Oncology Specialist): 4
- PT/Rehab: 3
- Hospice: 1
- Pharmacist (Primary Care): 1

Data up to 3/31/23
Abstracted data from 2 POEM sites. N=607 patients beginning treatment with oral anticancer agents (OAA). Non-pharmacist group at both sites had OAA patient care provided by clinic nurses prior to pharmacist start.
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Non-pharmacist group at both sites had OAA patient care provided by clinic nurses prior to pharmacist start.
Abstracted data from 1 POEM site. N=105 patients beginning treatment with IV High Emetic Risk Chemotherapy Regimens. Non-pharmacist group patient care provided by clinic nurses prior to pharmacist start.
Healthcare Utilization

Site 2 – IV HEC

Healthcare Utilization (0-3 months)

![Chart showing healthcare utilization percentages for ED visits and hospitalizations between pharmacist and non-pharmacist groups.]

- ED visits: 23% for Pharmacist (n=44), 23% for Non-pharmacist (n=61)
- Hospitalizations: 30% for Pharmacist, 33% for Non-pharmacist

Abstracted data from 1 POEM site. N=105 patients beginning treatment with IV High Emetic Risk Chemotherapy Regimens. Non-pharmacist group patient care provided by clinic nurses prior to pharmacist start.
Case Example 1:
Sotorasib - Hepatotoxicity

- POEM pharmacist provided OAA education for sotorasib
- Day 17 – OV with oncologist
  - Mild rash/pruritus – oncologist discussed options with POEM pharmacist – implemented loratadine +/- triamcinolone ointment if needed
  - Mild elevation in LFTs - no intervention indicated
- Day 35 – borderline Grade 3 LFT elevation – POEM pharmacist discussed with oncologist
  - Held sotorasib
  - Will restart once LFTs return to Grade ≤1 at 50% dose reduction (480 mg daily)
    - Restarted Day 49 – monitoring LFTs weekly going forward
- Day 55 – Grade 3 LFT elevation – POEM pharmacist notified oncologist
  - Held sotorasib
  - Will restart once LFTs return to Grade ≤1 at 50% dose reduction (240 mg daily)
    - Restarted Day 71 – monitoring LFTs weekly
- Day 76 – Grade 3 LFT elevation – POEM pharmacist notified oncologist
  - Sotorasib permanently held
Case Example 2: Selinexor – Nausea Regimen

• POEM pharmacist provided OAA education for selinexor
  • Highly emetogenic, nausea prophylaxis required. Generally recommended to include steroid + 5HT3RA + NK1RA or olanzapine.
    • Steroid already ordered by oncologist for myeloma treatment.
    • Pharmacist opted to avoid 5HT3RA, as patient has congenital long QT syndrome, and olanzapine, due to patient’s age (77). Pharmacist added oral NK1RA for nausea prevention along with trimethobenzamide PRN for breakthrough N/V.
• Day 15 – Follow-up visit with POEM pharmacist
  • Tolerating well, no nausea
• Day 35 – Follow-up visit with oncologist
  • Tolerating well, no nausea
• Day 55 – Follow up visit with POEM pharmacist
  • Pharmacist and patient discussed trial decrease of NK1RA dose since nausea well-controlled throughout initial 2 months
• Day 62 – Follow up visit with oncologist, increased selinexor dose → visit with POEM pharmacist to discuss change in regimen
• Day 90 – Follow up visit with oncologist, change in treatment plan due to progression
Patient Experience Survey

**Overall satisfaction across all items:** 91% Strongly agree, 7% Somewhat agree, 1% neither, <1% disagree

- It is important for a patient beginning cancer treatment to meet with a pharmacist
- After speaking with the pharmacist, I feel more knowledgeable about my cancer treatment
- After speaking with the pharmacist, I’m more confident about how to manage side effects from my cancer treatment
- Overall, I’m satisfied with the care provided by the pharmacist

N=394
Patient Experience

• “The pharmacist was kind and knew everything we needed to know. We are always grateful for the hard truths. She covered those with professional grace. Thank you.”
• “The pharmacist was fantastic! I seriously consider this time with her extremely helpful!”
• “The pharmacist was very thorough and also very receptive to my many questions which is important to me. She also followed up on an additional question I emailed her a little later in the day. I feel the opportunity to speak with her was very helpful as I begin treatment with many possible side effects.”
Physician Experience Survey

Overall satisfaction across all items: 83% Strongly agree, 13% Somewhat agree, 3% neither, <1% disagree

N=40 (70% RR) Completed December 2022
Physician Experience

• “The pharmacist has made a huge impact on the quality and safety of oral chemotherapy in my patients.”
• “Clinical pharmacist is an excellent resource for me to find help to improve care.”
• “The clinical pharmacist is doing a great job. I can’t imagine caring for our patients without her help.”
• “More dedicated pharmacists. Replicate the model everywhere.”
Physician Experience

What has been most impactful to patient care regarding the pharmacist’s work within your practice?
Having a pharmacist in our practice has allowed us to have the expertise needed for patients initiating complicated oral agents that often carry significant toxicities and drug interactions. Our RNs were not equipped to do this properly and the physician visits are not sufficient to cover what they patient need. The pharmacy support from many specialty pharmacies does not interact with the physician and has no further context for the pt care.

Are there areas of oncology patient care you believe are best suited for a pharmacist? If yes, what are they?
We chose to focus on oral chemotherapy in the outpt setting and this has been extremely valuable. We already had inpatient support- if we didn’t, this would take priority.
We also have her helping with comorbidity management as it relates to cancer treatment- eg Diabetes and HTN that worsen with treatment. This has been very helpful for all involved and the PCPs appreciate the support.

Kathleen Beekman, MD IHA Hematology/Oncology
Fortuitous Outcomes

• Cancer Drug Repositories (CDRs)
  • Responds to challenges related to drug affordability, access and waste
  • 13 states currently allow cancer medication donation and redistribution, including Michigan
  • 3 POEM programs have initiated CDRs and have shared best practices, pearls, etc.
    • MyMichigan Cancer Center – Midland
    • Cowell Family Cancer Center, Munson – Traverse City, Cadillac, Gaylord, Grayling
    • The Cancer and Hematology Centers – Grand Rapids
CDR – Experience to Date

• Munson Healthcare (12/2021 – 6/2023)
  • 70 donations received, value = $1,319,705.88
  • 16 patients been provided donated meds, value = $165,798.39
• MyMichigan Health (11/2021 – 6/2023)
  • 58 donations received
  • 11 patients been provided donated meds, value = $83,989.29
• The Cancer & Hematology Centers (1/2023 – 6/2023)
  • Total donations received, value = $1,008,306.87
  • 3 patients have been provided donated meds, value = $53,517.37
• Of the 3 sites
  • Over 150 medications collected in total ~18 month time period, equaling approximately $3 million in medications not wasted
  • 30 prescriptions provided to patients in need
CDR – Statewide Effort

• Despite successes of individual programs, a need for support is evident
• MOQC, POEM, and current CDR sites in Michigan have worked together to determine next steps for a State-wide repository
• Goals –
  • Expand patient access to oral anticancer agents and supportive medications across the State
  • Make cancer drug donation more streamlined and feasible at sites that do not currently have repositories in place
CDR – Statewide Effort

- Non-profit*, State-wide Repository – YesRx
- Buy-in/interest from multiple organizations across the State
- Near term
  - Centralized database with coordination between current sites
  - Onboarding of new sites/practices
  - Evaluation of centralized medication inventory options
- Long term
  - Expansion across the State for anticancer meds
  - Expansion to non-cancer medications
- Contact – estunteb@umich.edu

*Non-profit application filed June 2023
In the meantime – CDR Donations

• For patients interested in donating
  • In all scenarios, the donor must complete a donation form and medication must meet requirements for donation
  • May donate at the 3 sites currently registered in the State
  • May donate to other available programs, for example www.safenetrx.org (Iowa)
• Sites interested in collecting donations from patients
• Can register with MI LARA to collect donations
In the meantime – CDR Prescribing

• For patients in need and not at one of the CDR sites
  • MyMichigan Health and The Cancer and Hematology Centers sites will fill a CDR prescription for a patient in need with a prescription from a non-site Michigan oncologist
  • Unable to ship prescriptions at this time, the patient will need to pick up at the site
  • Patient/recipient will sign the CDR cancer drug recipient record form at the site
• More to come SOON regarding opportunities across the State with YesRx
Conclusion

• Integration of pharmacists in oncology clinics has improved quality of care and resulted in high patient and physician satisfaction
• Outcomes expand beyond the site by partnering with the group, sharing best practices, and developing innovative models for helping patients – i.e. CDR efforts
• Please let us know if you’re interested in participating or hearing more!
POEM Pharmacists

Jamie George, PharmD
Henry Ford Health System
Macomb-Clinton Township

Emily Johengen, PharmD, BCACP
IHA Hematology/Oncology
Ypsilanti, Brighton, Canton, Chelsea, Livonia

Colton Zwart, PharmD, BCOP
Munson Healthcare
Traverse City, Cadillac, Charlevoix, Gaylord, Grayling, Manistee

Katie Sias, PharmD, BCOP
MyMichigan
Mt. Pleasant, Midland, Alpena, Alma, Gladwin

Mark Wagner, PharmD, BCOP
Munson Healthcare
Traverse City, Cadillac, Charlevoix, Gaylord, Grayling, Manistee

Olga Yankulina, PharmD,
Henry Ford Health System
Novi

Jennifer VanSickler, PharmD
Sparrow Herbert-Herman Cancer Center
Lansing

Sites with Pharmacists Starting Summer 2023!

The Cancer and Hematology Centers
Grand Rapids, Holland, Norton Shores

Corewell Health
Grand Rapids

Covenant HealthCare
Saginaw
POEM Coordinating Center Team

Mike Harrison
POQC Member
POEM Representative
Closing Items

Keli DeVries, LMSW
Continuing Education Credits

This meeting has been approved for 5.25 CEU

1. MOQC will send out the evaluation to everyone’s email address as part of the follow-up email
2. Attendees should complete the evaluation
3. Attendees will receive a certificate from the CE accreditation organization with their credits
   • The certificate will be sent from ipceapps@umn.edu

Questions? Please reach out to moqc@moqc.org
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
### Next Meetings

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Register at: [https://moqc.org/events/](https://moqc.org/events/)
# 360 Evaluation

MOQC has great value for oncology in Michigan in bringing together practices across the state, sharing data across the country, as well as presenting the patient care perspective in oncology treatments, palliative care and comfort care.

**Physician**

MOQC lives up to its mission - improvement of quality of care for patients. The intent is genuine. MOQC listens to the participating practices and offers valuable content and resources to achieve improvement in quality.

**Physician**

I enjoy collaborating with other practices to look at best workflows. I appreciate MOQC’s focus on equity and how we can all make sure patients receive high quality care.

**Practice Manager**

MOQC’s biggest strength is the presentation of data from all practices. It is helpful being able to compare how we are doing and find areas of improvements.

**Pharmacist**

I appreciate the care and focus that MOQC provides to patients and caregivers. MOQC holds physicians and practices to a higher standard for patient care.

**POQC Member**

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**POQC Member**
THANK YOU!
Cancer care. Patients first.
The best care. Everywhere.