MOQC Measures

Lydia Benitez, PharmD, BCOP
Lynn Henry, MD, PhD

2025 Value-Based Reimbursement Summary

MICHIGAN ONCOLOGY QUALITY CONSORTIUM

Region-Level

Meet 4 of the following 5

• Olanzapine given with high emetic risk chemotherapy	60%
• NK1RA given for low or moderate emetic risk cycle 1 chemotherapy	10%
• Hospice enrollment	65%
• Hospice enrollment more than 7 days before death	60%
• 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	75%

2% Opportunity

2025 Measure Targets

MEQC Measure

Total eligibility: **12%**

VBR Measure

Total eligibility: up to **7%**

MEQC practices are only eligible for the 12% VBR

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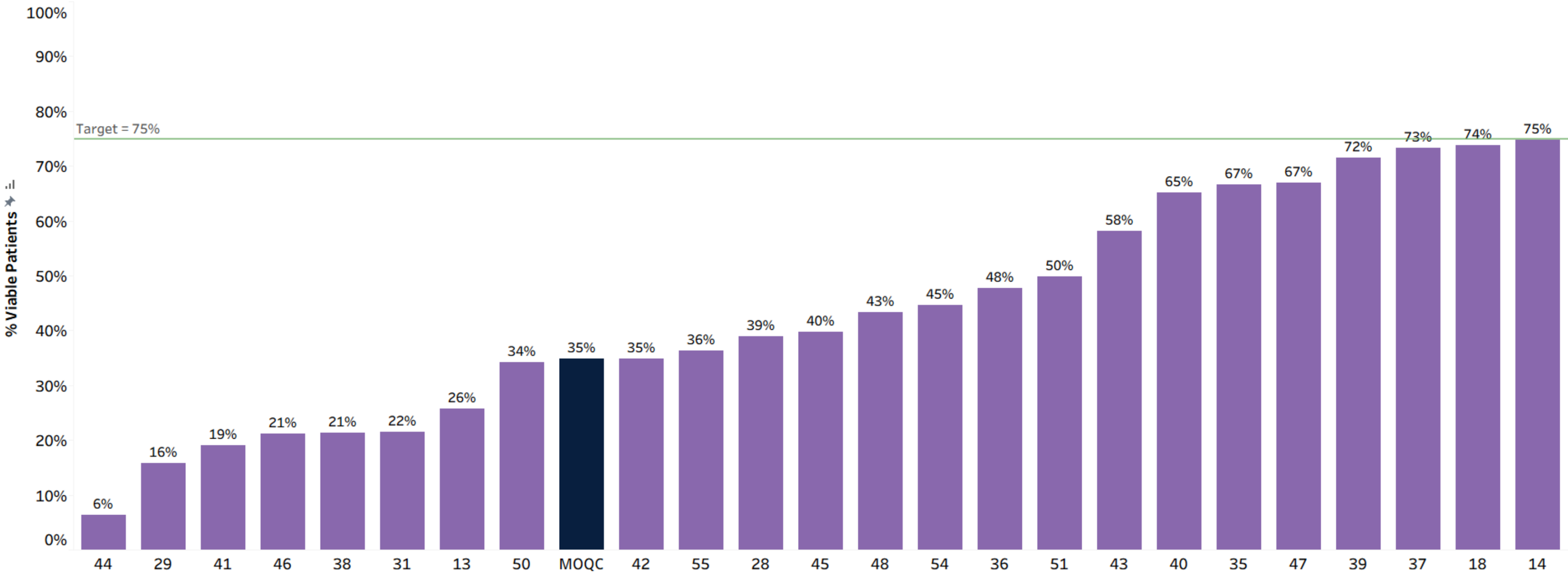
2025 Additional Criteria for Receiving VBR

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

Proportion of Patient Lists Eligible for Abstraction, Round 2 2025



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

Measures

- Tobacco cessation counseling or referral
- Designated patient advocate documentation
- Complete family history
- NK1RAs with low/moderate emetic risk chemotherapy
- Olanzapine as part of a 4-drug antiemetic regimen (high emetic risk chemotherapy)

CHART SELECTION CRITERIA

Chart Selection Criteria for Presented Data

Abstracted January 1, 2025 – December 31, 2025

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

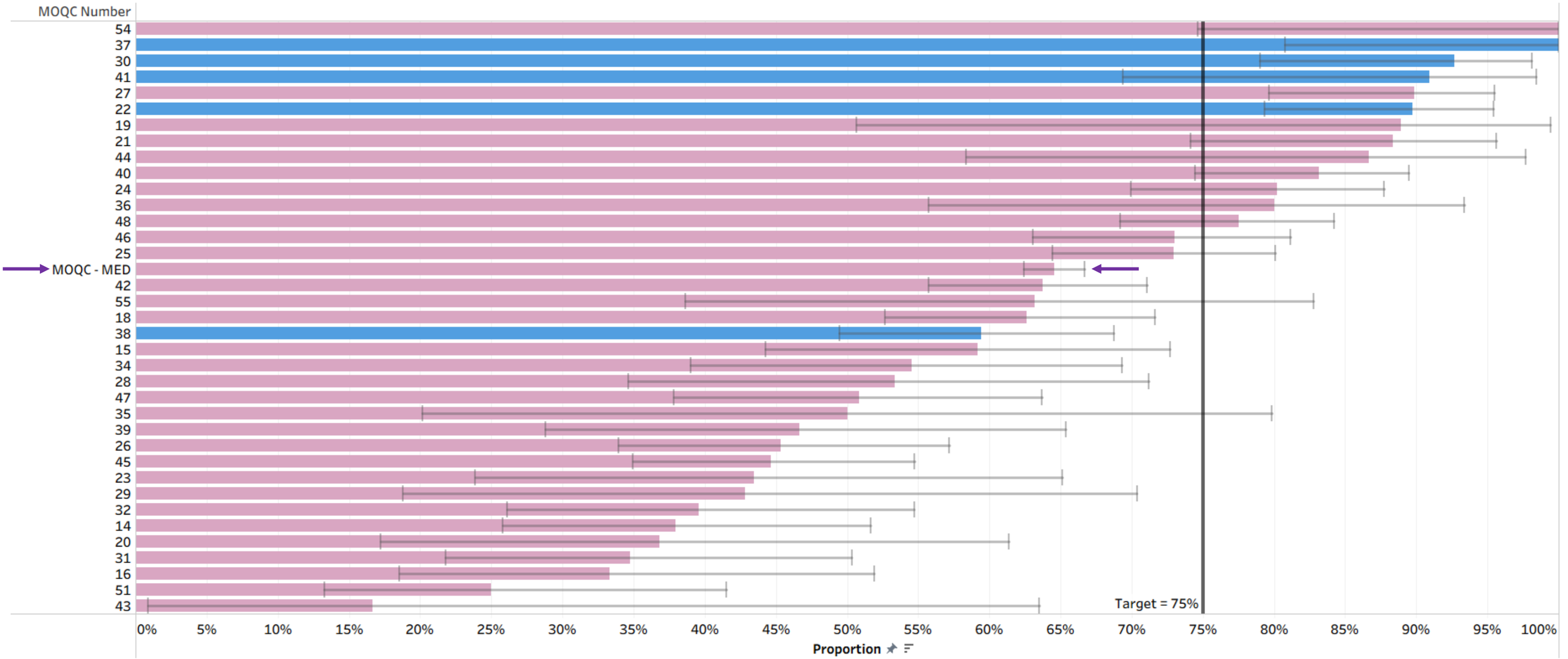
Diagnosis & Visit Window
Diagnosed: 12/1/2023 – 9/30/2025
First Office Visit: 12/1/2023 – 11/30/2025
2 Office Visits (practitioner): 10/1/2024 – 11/30/2025

MEQC Measure

VBR Measure

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

1/1/25 - 12/31/25, n = 1,959



Performance Compared to Prior Year

No Significant Change

Improved

MEQC Measure

VBR Measure

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

Non-Clinical Interventions that Impact Survival

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

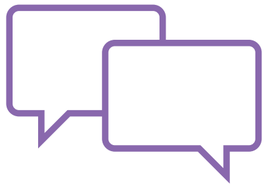

JAMA Oncology | Original Investigation

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

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

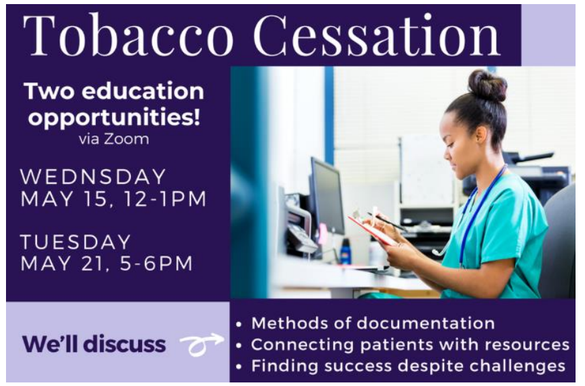
Other Interventions:

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



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

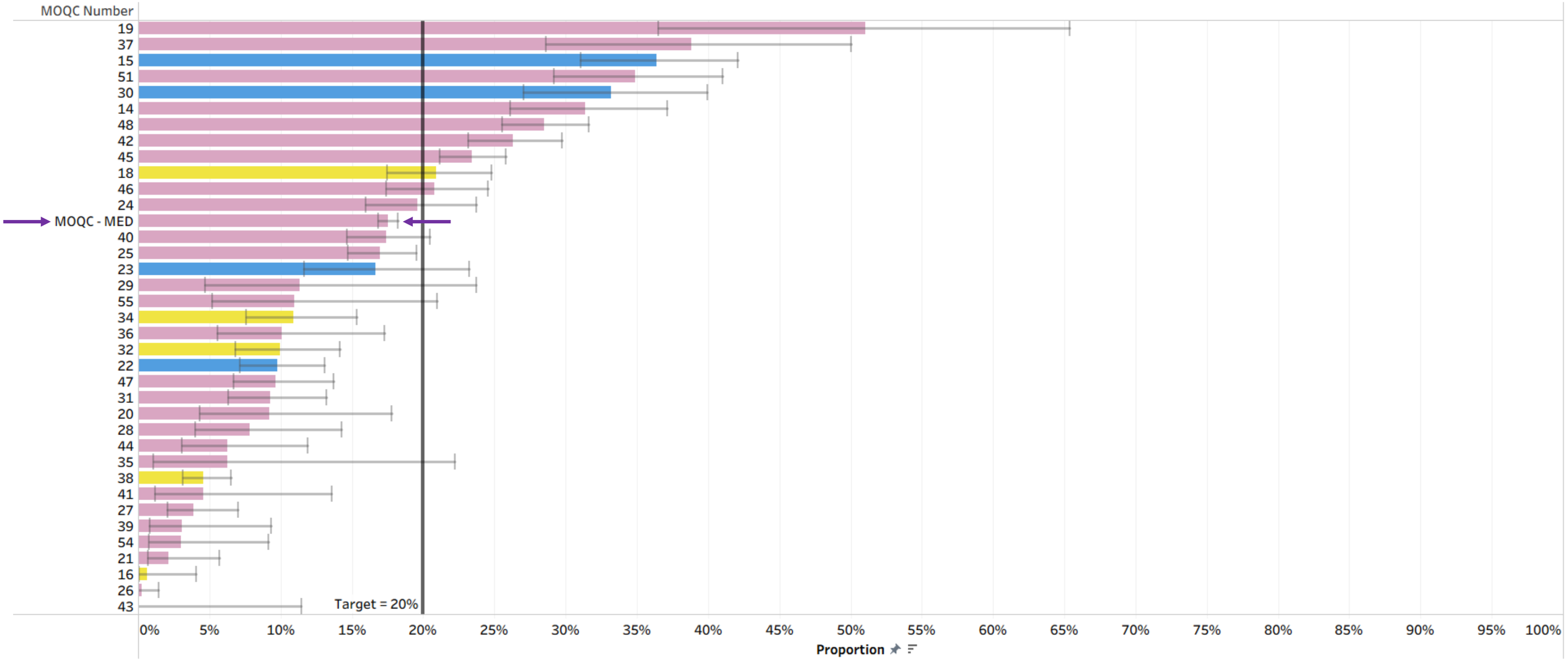
Interprofessional Development Education Sessions can be found at https://moqc.org/eventspace/



Tobacco Cessation IPD Session

MEQC Measure

103: Designated Advocate Documented on a Legally Recognized Document in the Inpatient or Outpatient Medical Record
1/1/25 - 12/31/25, n = 11,662



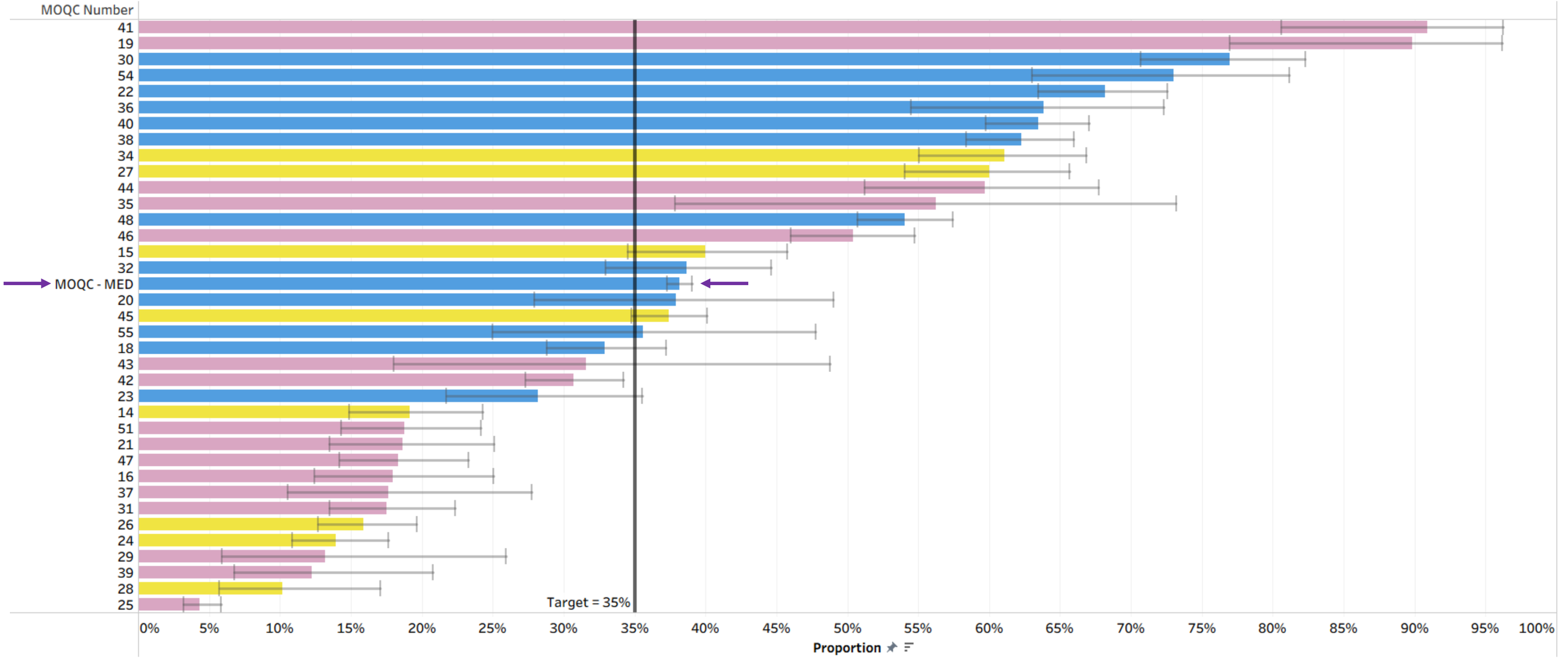
Performance Compared to Prior Year
- No Significant Change
- Improved
- Worsened

MEQC Measure

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

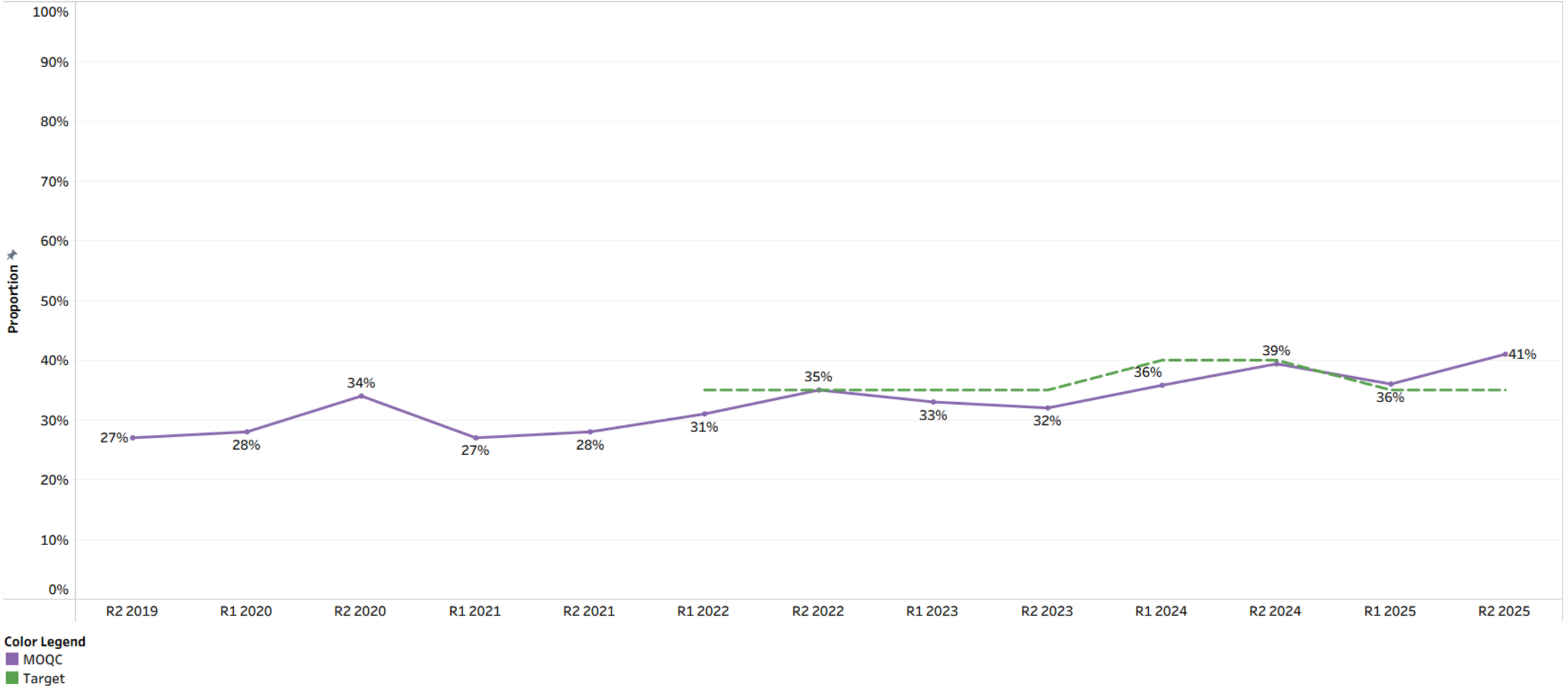
VBR Measure

108a: Complete Family History Documented for Patients with Invasive Cancer
1/1/25 - 12/31/25, n = 11,662



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

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



Hereditary Cancer Questionnaire

Name: _____ Date of Birth: _____

Today's Date: _____

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

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

Be as thorough as possible

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

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

Are you of Ashkenazi Jewish descent? ❑ Yes ❑ No

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

_____ _____

Clinician's Printed Name Clinician's Signature

Created in partnership with Munson

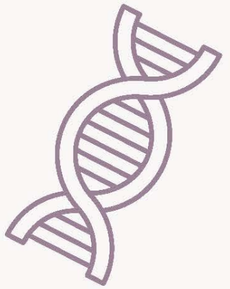
Cancer Genetic Counseling: What to Know

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

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

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

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



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

What happens during a genetic counseling appointment?

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

What kind of sample is used for genetic testing?

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

What information could I get from genetic testing?

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

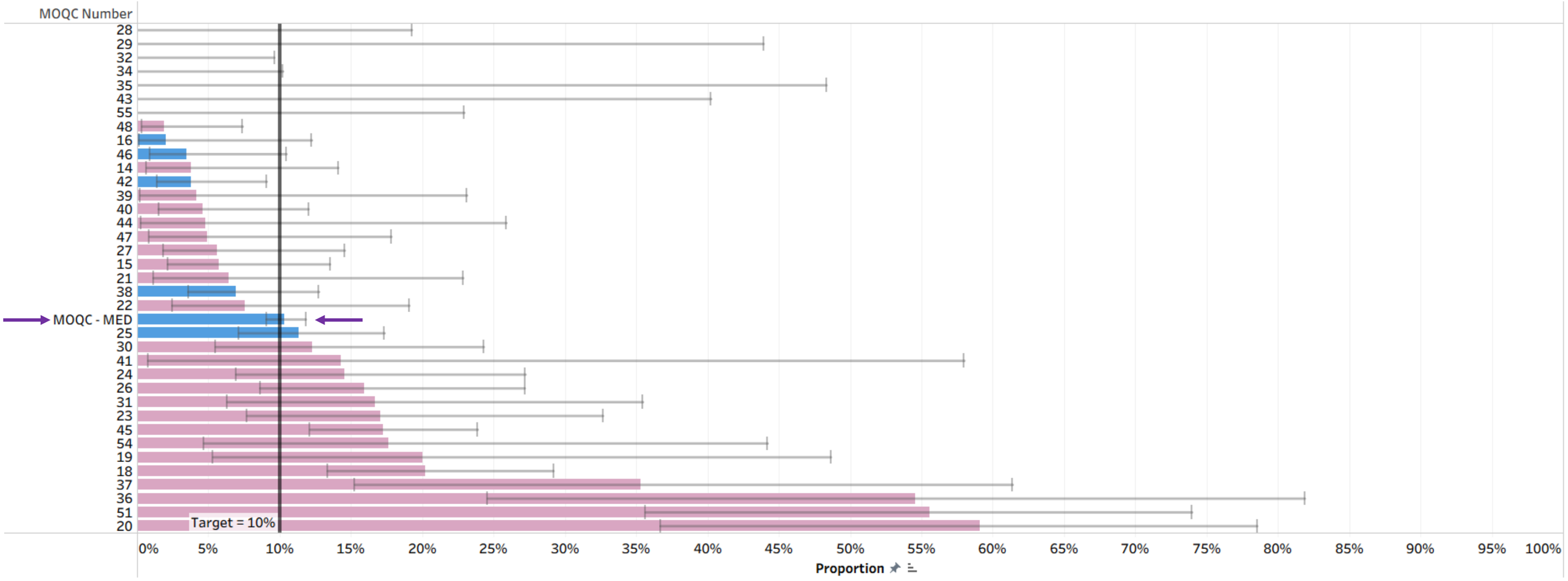
MEQC Measure

VBR Measure

114: NK1RA with Cycle 1 of Low or Moderate Emetic Risk Chemotherapy

(Lower Score = Better)

1/1/25 - 12/31/25, n = 1,952



Patients receiving treatment on antiemetic clinical trial excluded.

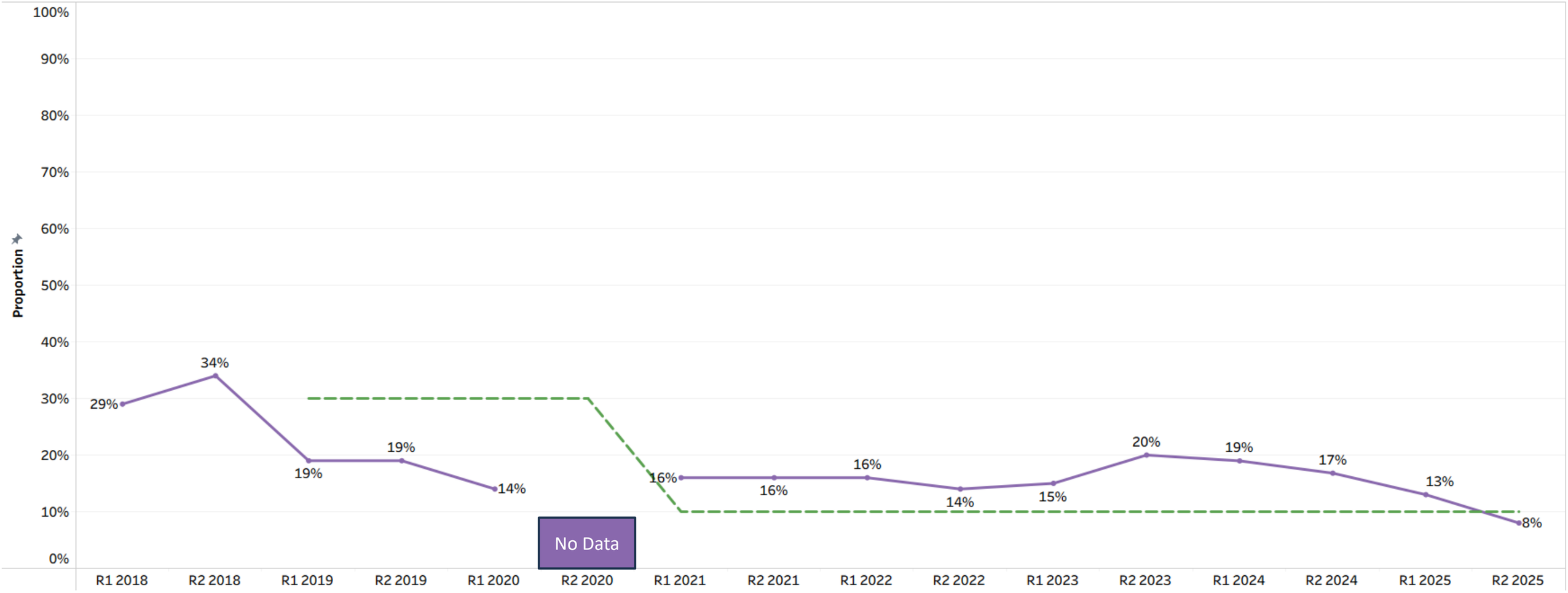
Performance Compared to Prior Year

- No Significant Change
- Improved

MEQC Measure

VBR Measure

114: NK1RA with Cycle 1 of Low or Moderate Emetic Risk Chemotherapy
(Lower Score = Better)



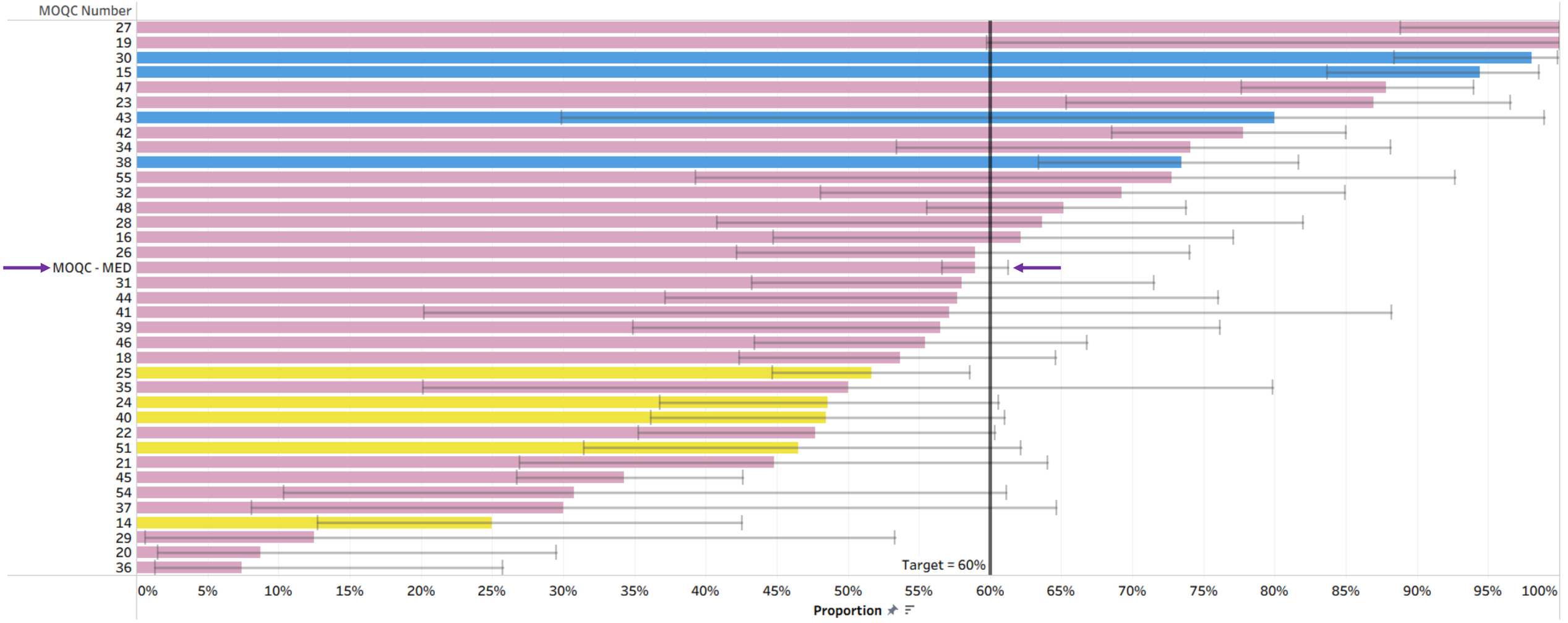
Color Legend
- MOQC
- Target

MEQC Measure

VBR Measure

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

1/1/25 - 12/31/25, n = 1,756



Patients receiving treatment on antiemetic clinical trial excluded.

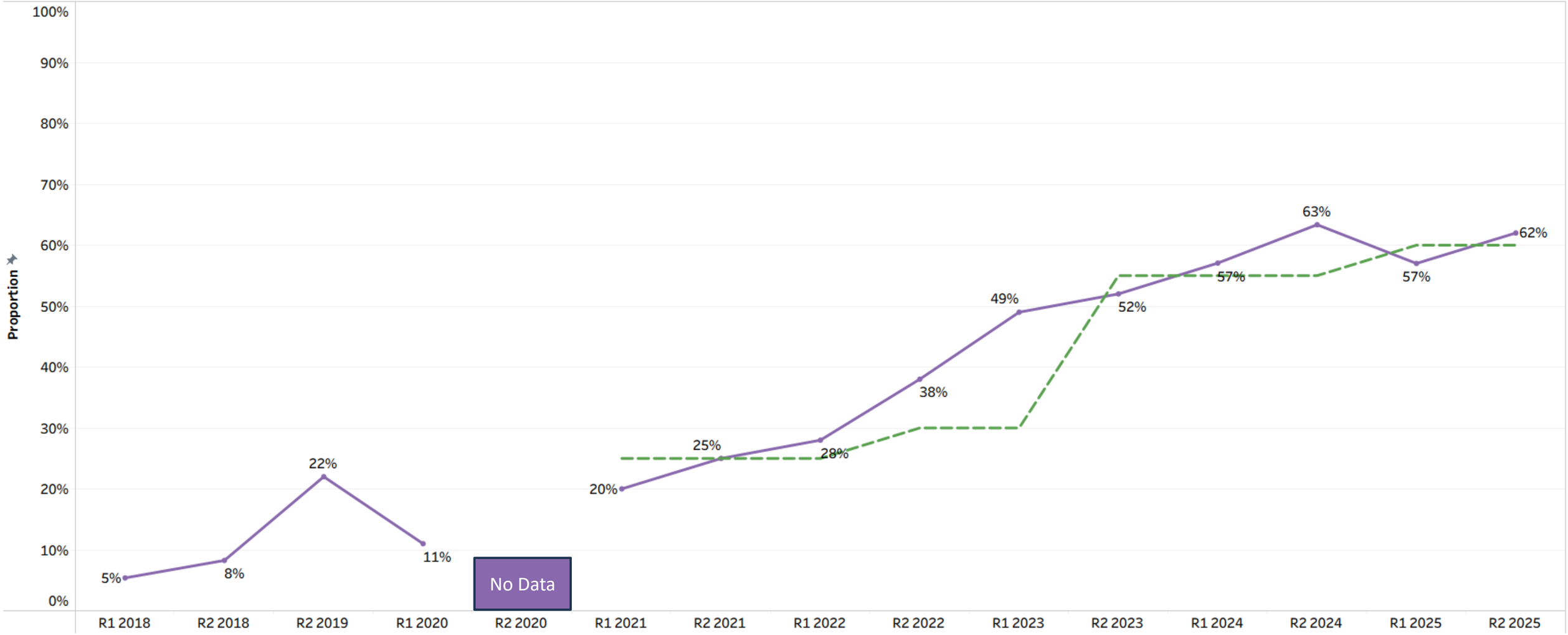
Performance Compared to Prior Year

- No Significant Change
- Improved
- Worsened

MEQC Measure

VBR Measure

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



Low-Dose Olanzapine as Part of a 4-Drug Regimen

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Patients receiving highly emetogenic chemotherapy for solid tumors
(N = 275)

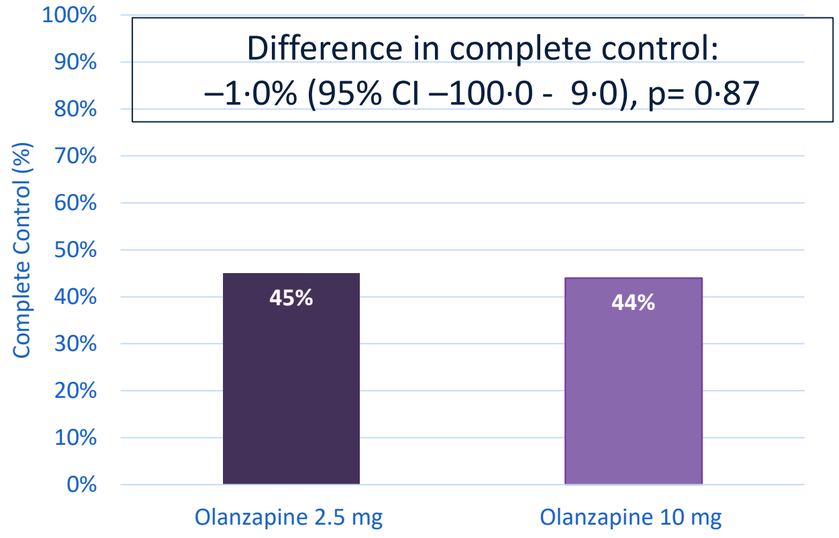
Olanzapine 2.5 mg days 1 through 4
In addition to NK1RA, 5-HT3RA, and dexamethasone
(n =134)

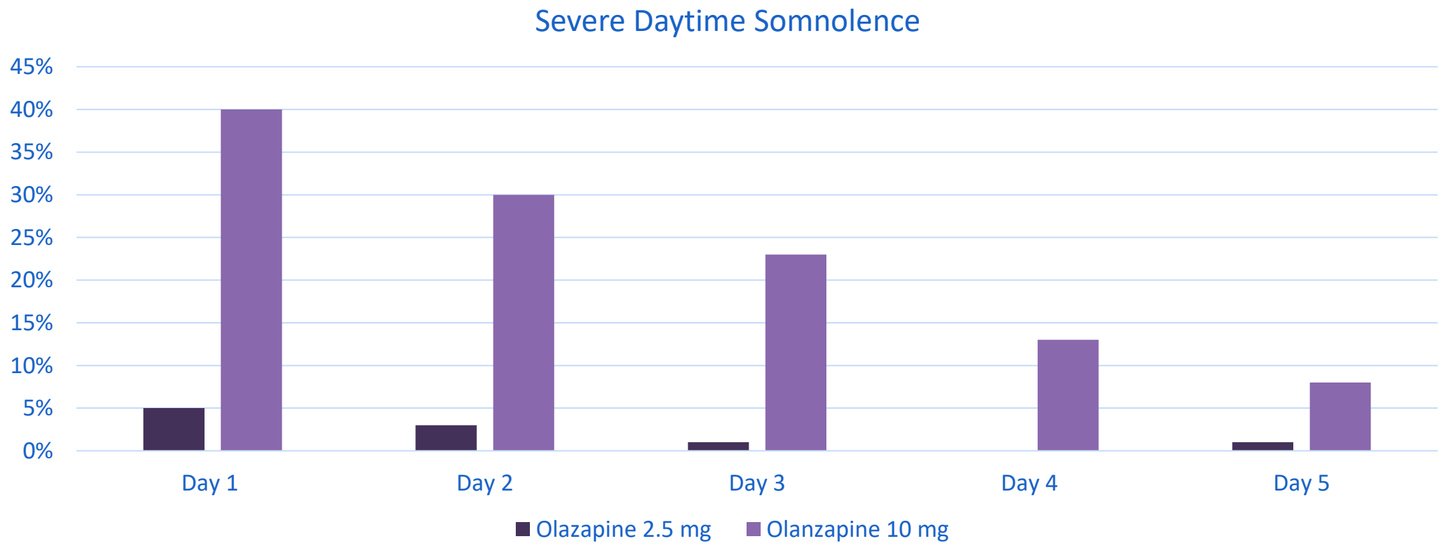
Olanzapine 10 mg days 1 through 4
In addition to NK1Ra, 5-HT3RA, and dexamethasone
(n = 141)

Primary Endpoint

Complete control defined as:
- No emetic episodes
- No use of rescue medications
- No/mild nausea

Phase III non-inferiority randomized controlled trial
Non-inferiority margin: 10% difference in 1 yr endpoint (one-sided 95% CI)





Bajpai J et al. Lancet Oncol 2024; 25: 246–54

OLANZAPINE

WHY AM I GETTING A PRESCRIPTION FOR OLANZAPINE?

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

WHAT SHOULD I EXPECT WHEN I GO TO THE PHARMACY?

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

WHAT ABOUT THE SIDE EFFECTS?

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

IS OLANZAPINE COVERED BY INSURANCE? IS IT EXPENSIVE?

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

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

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

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Blue Cross Blue Shield of Michigan
Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

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

What is this measure?

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

Why is this measure important?

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

What is included in this measure?

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

Where can abstractors find this information?

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

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

Measure Takeaways

- **Prevention and Risk Assessment**
  - Performance for tobacco cessation (101b) has been stable
    - No practice saw a significant decline in performance
  - Complete family history (108a) has improved across MOQC, above the target for 2025
- **Care Coordination**
  - MOQC is almost to the target for designated patient advocate (103)
- **Antiemetics**
  - Performance for NK1RA on low/moderate emetic risk chemo (114) has steadily improved across MOQC
  - Performance for olanzapine on high emetic risk chemo (115) is meeting target (with confidence interval)

MOQC
MICHIGAN ONCOLOGY QUALITY CONSORTIUM

DISCUSSION

End-of-Life Measures

- Hospice enrollment
- Time on hospice
- Anticancer therapy administration
- Palliative care consultation

CHART SELECTION CRITERIA

Chart Selection Criteria for Presented Data

MOQC
MICHIGAN ONCOLOGY QUALITY CONSORTIUM

Abstracted January 1, 2025 – December 31, 2025

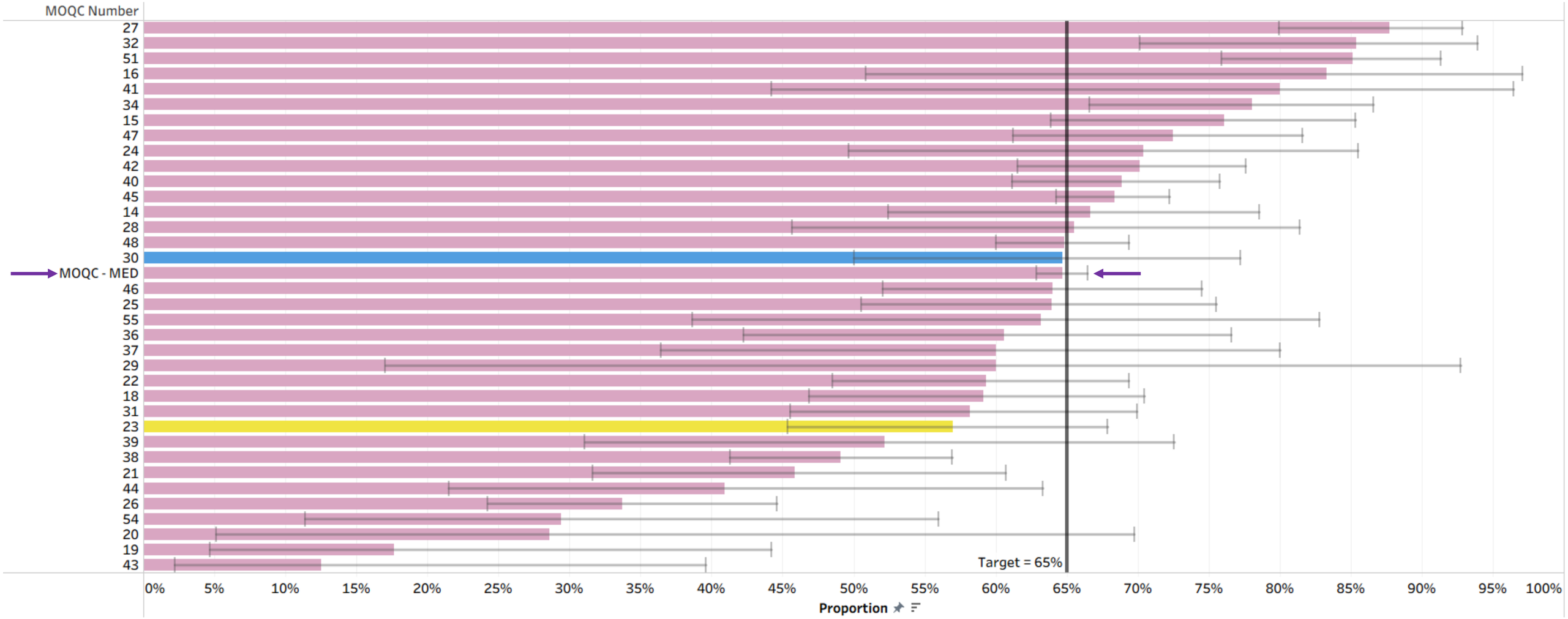
Eligible Patient Criteria
18 or older at diagnosis
Invasive malignancy or hematologic malignancy*

EOL patients only need to meet criteria below:
Patient must have died 12/1/2023 – 11/30/2025
Patient must have a known date of death
Death related to cancer or cancer-related treatment
2 office visits (practitioner): Within 12 months preceding death

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

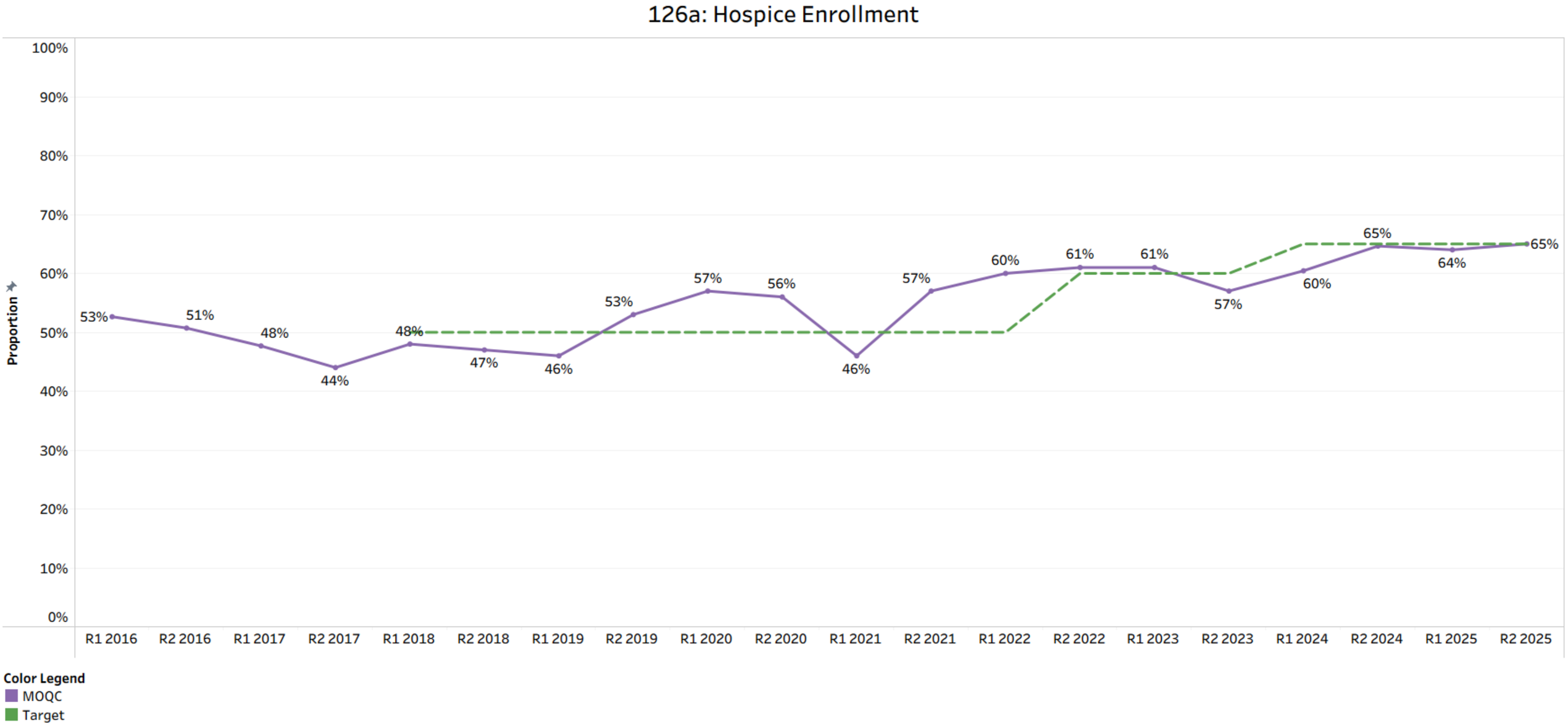
VBR Measure

126a: Hospice Enrollment
1/1/25 - 12/31/25, n = 2,841



Patients with hematologic malignancies excluded.

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


126a: Hospice Enrollment
Proportion
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
53%
51%
48%
44%
48%
47%
46%
53%
57%
56%
46%
57%
60%
61%
61%
57%
60%
65%
64%
65%
R1 2016
R2 2016
R1 2017
R2 2017
R1 2018
R2 2018
R1 2019
R2 2019
R1 2020
R2 2020
R1 2021
R2 2021
R1 2022
R2 2022
R1 2023
R2 2023
R1 2024
R2 2024
R1 2025
R2 2025
Color Legend
MOQC
Target

Letter Templates

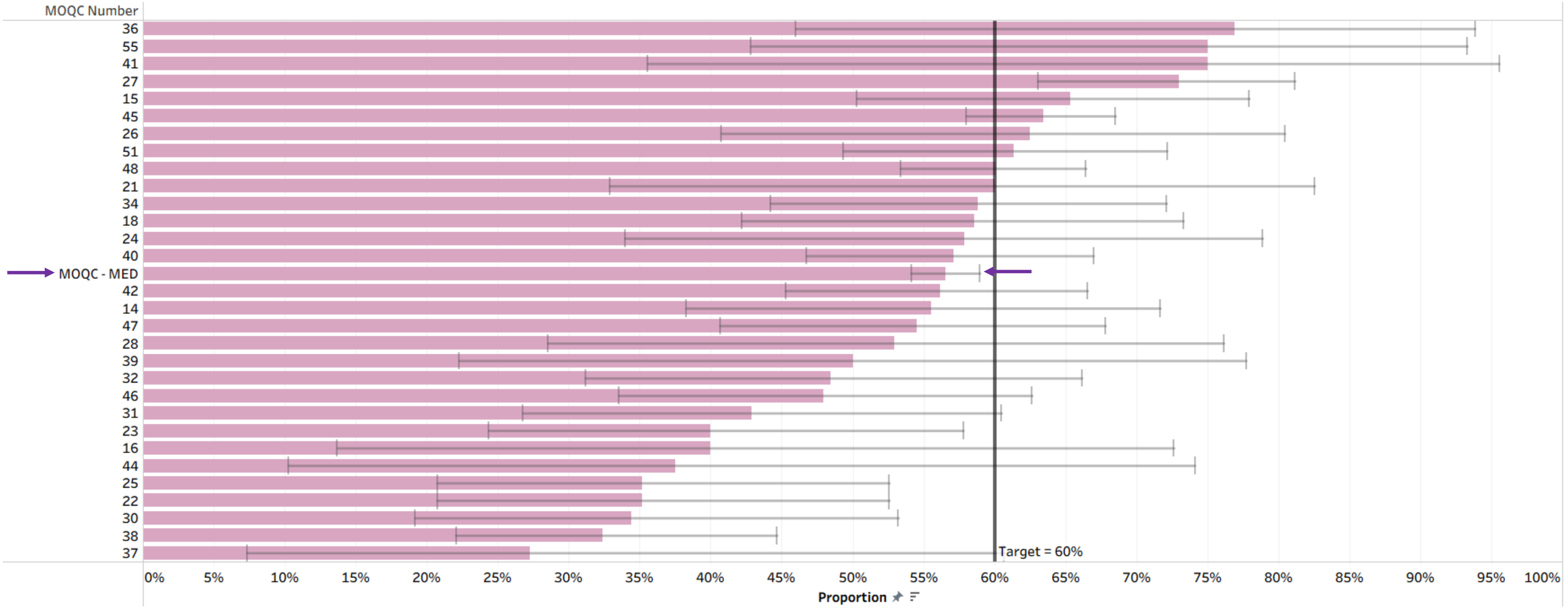
- Hospice Patient Enrollment Notification Template
- Hospice Patient Death Notification Template

MOQC Pathways

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

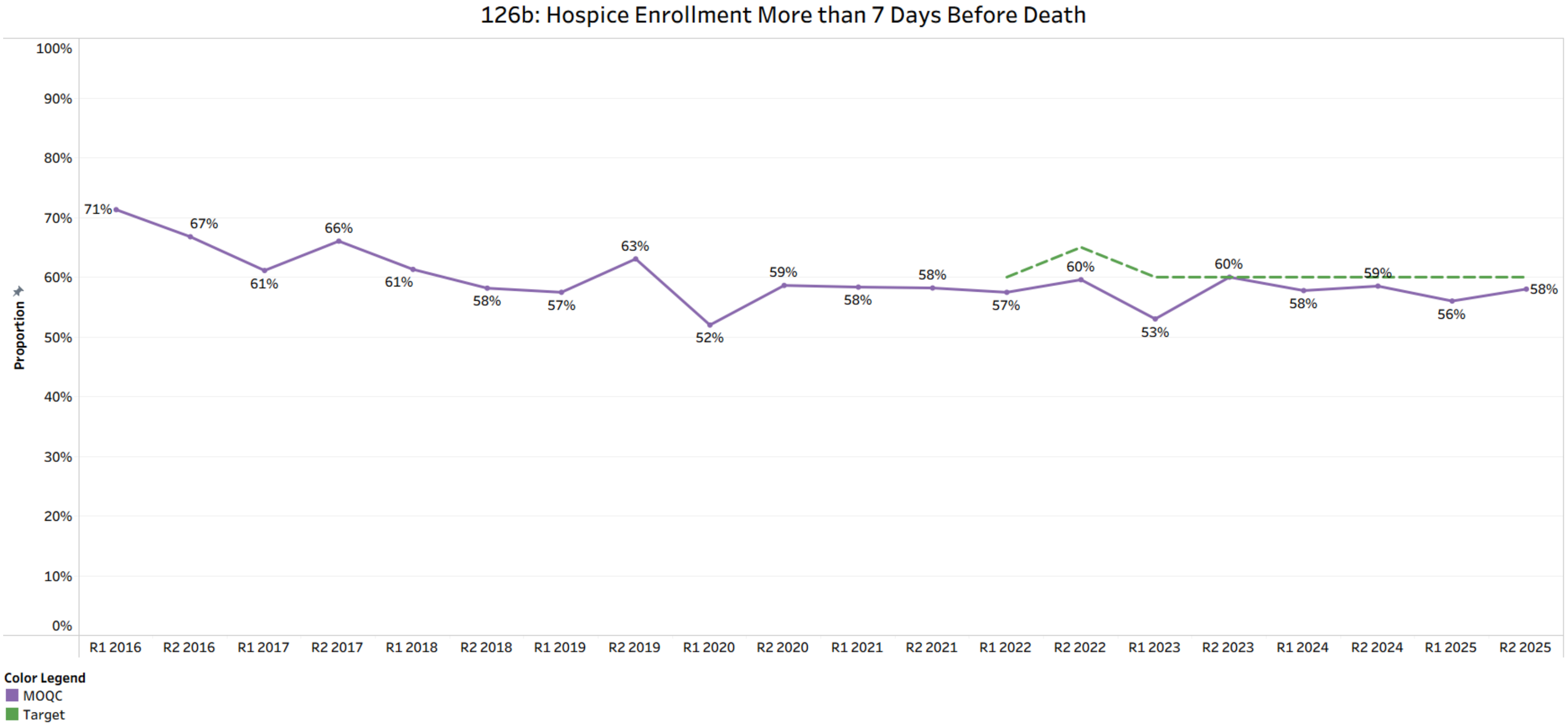
VBR Measure

126b: Hospice Enrollment More than 7 Days Before Death
1/1/25 - 12/31/25, n = 1,653



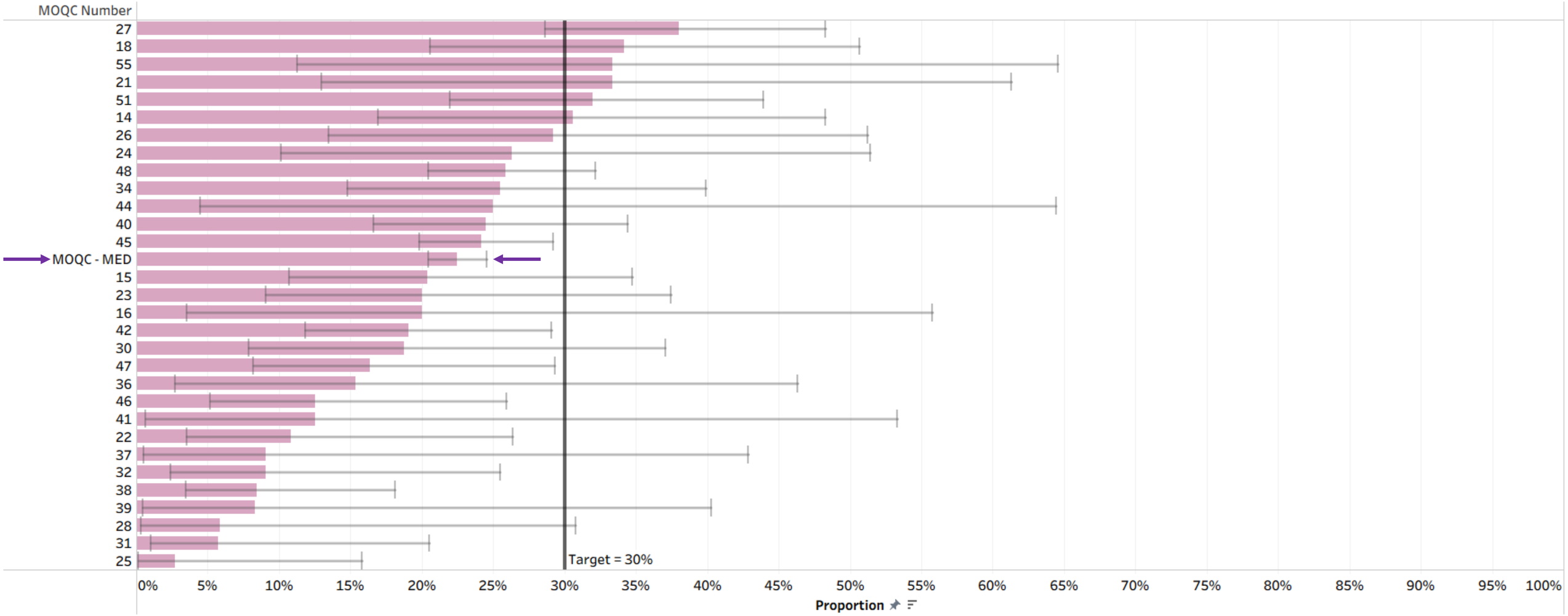
Patients with hematologic malignancies excluded.

Performance Compared to Prior Year
No Significant Change


126b: Hospice Enrollment More than 7 Days Before Death
Proportion
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
71%
67%
61%
66%
61%
58%
57%
63%
52%
59%
58%
58%
57%
60%
53%
60%
58%
59%
56%
58%
R1 2016
R2 2016
R1 2017
R2 2017
R1 2018
R2 2018
R1 2019
R2 2019
R1 2020
R2 2020
R1 2021
R2 2021
R1 2022
R2 2022
R1 2023
R2 2023
R1 2024
R2 2024
R1 2025
R2 2025
Color Legend
MOQC
Target

MEQC Measure

126c: Hospice Enrollment More than 30 Days Before Death
1/1/25 - 12/31/25, n = 1,653



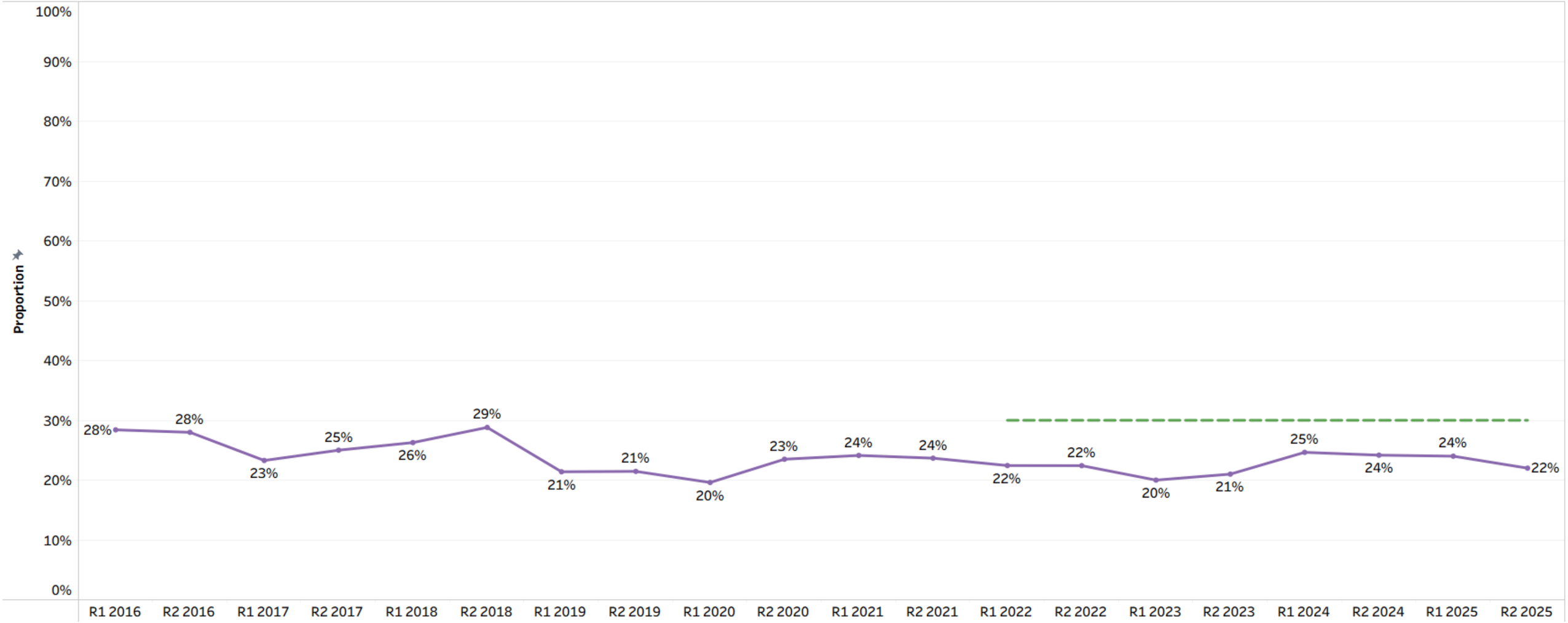
Patients with hematologic malignancies excluded.

Performance Compared to Prior Year

No Significant Change

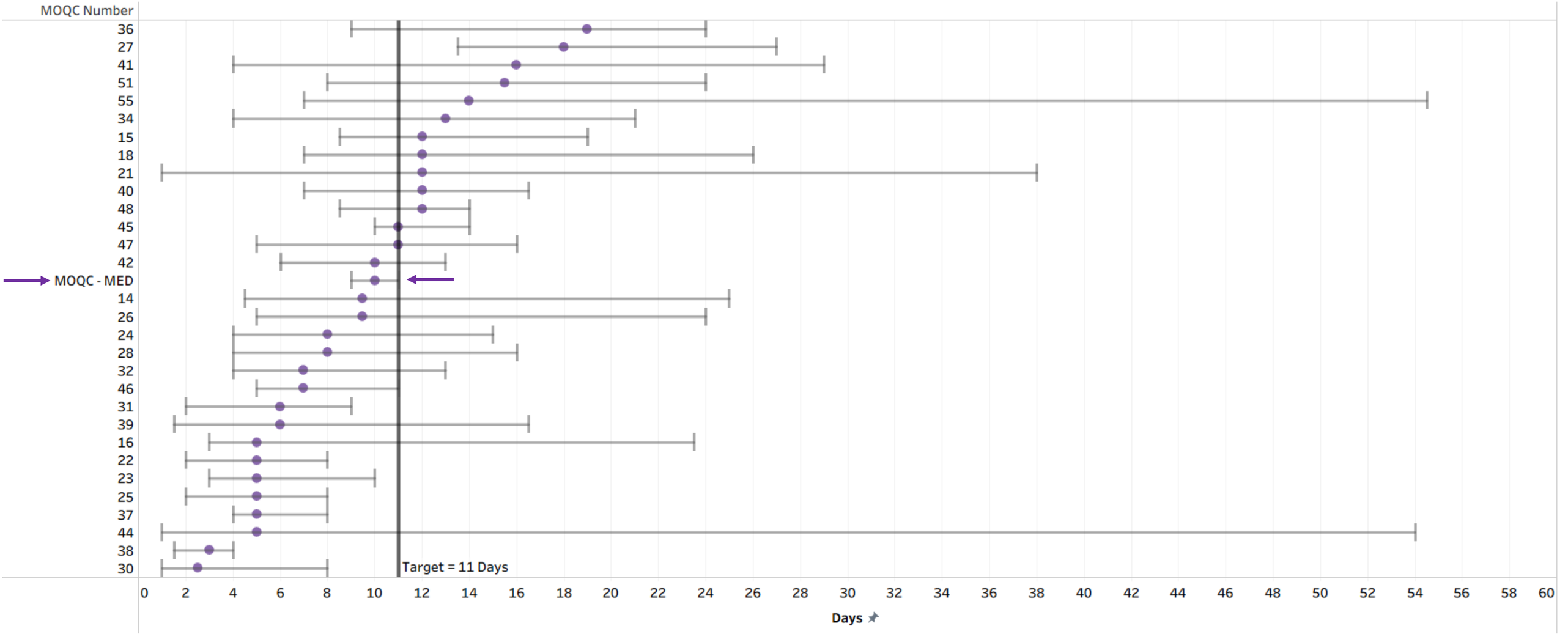
MEQC Measure

126c: Hospice Enrollment More than 30 Days Before Death



Color Legend
- MOQC
- Target

126d: Median Days on Hospice
1/1/25 - 12/31/25, n = 1,660



Patients with hematologic malignancies excluded.

WHAT MATTERS TO YOU?

Deciding if Hospice is Right for You

CONVERSATION GUIDE

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

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

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

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

YOUR WELL-BEING IS IMPORTANT.

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

HOW CAN HOSPICE HELP?

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

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

WHAT ELSE SHOULD I KNOW?

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

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

Ask about hospices in your area.

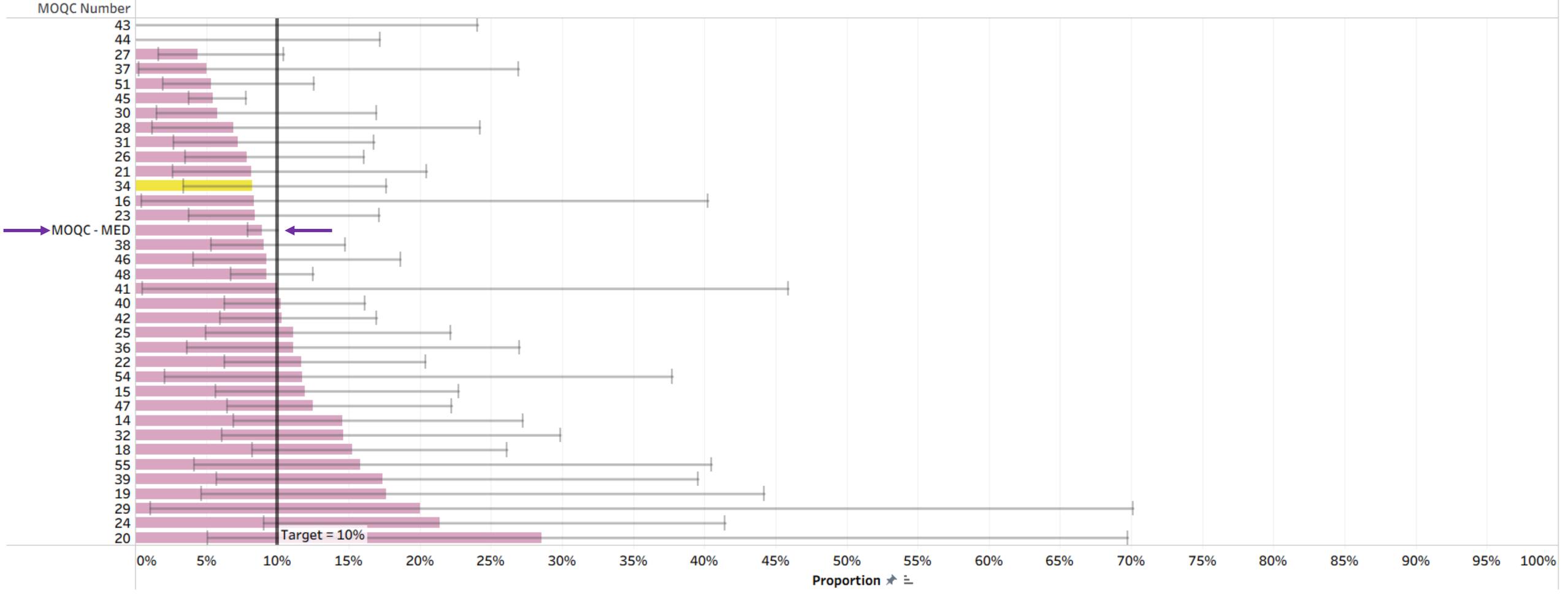
MQQC

Is HOSPICE Right for MY LOVED ONE and Me?

127a: Any Anticancer Therapy, Including Chemotherapy, Administered within the Last 14 Days of Life

(Lower Score = Better)

1/1/25 - 12/31/25, n = 2,879

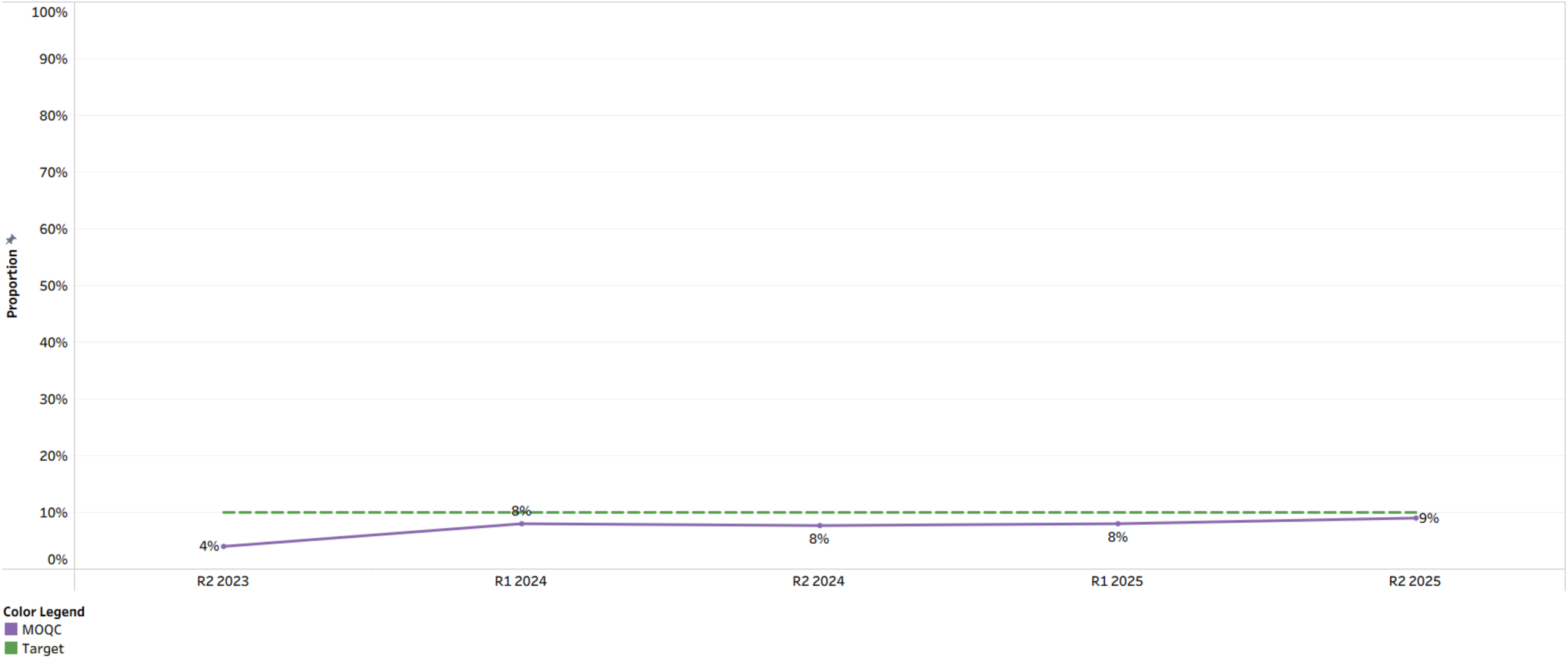


Patients with hematologic malignancies excluded.

Performance Compared to Prior Year

- No Significant Change
- Worsened

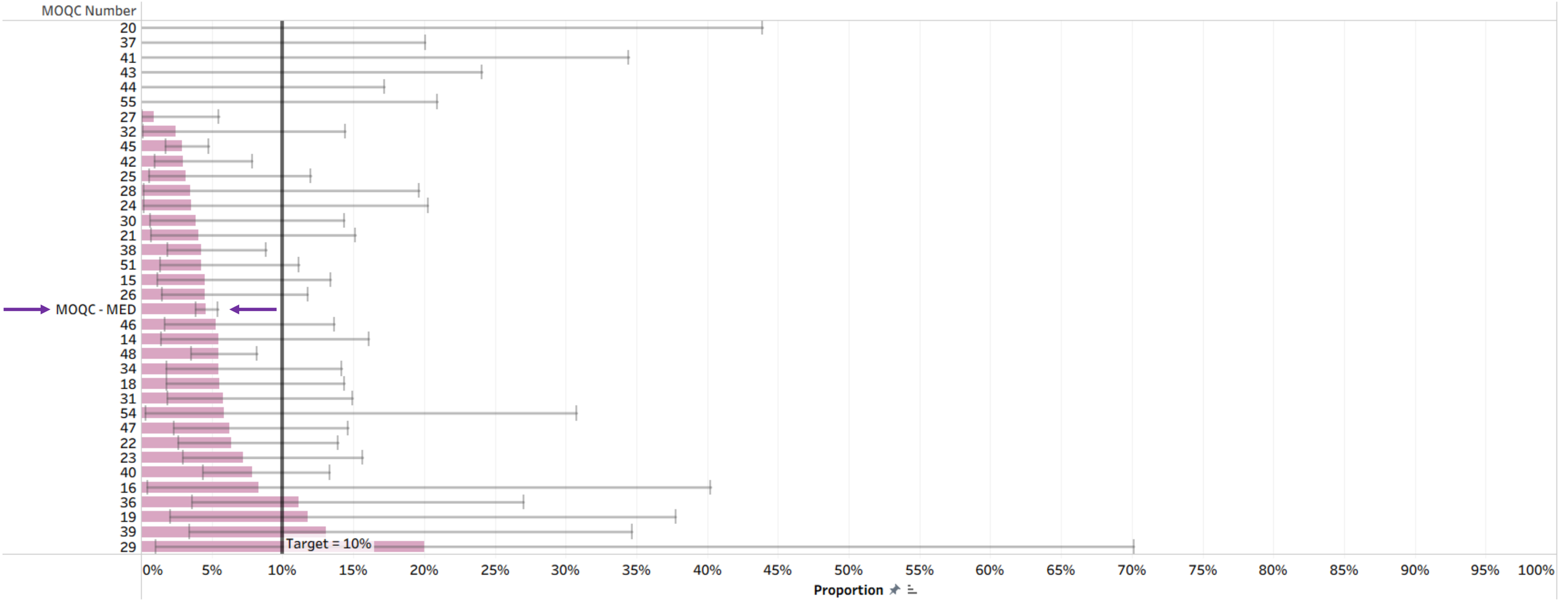
127a: Any Anticancer Therapy, Including Chemotherapy, Administered within the Last 14 Days of Life (Lower Score = Better)



128: Non-Chemotherapy Anticancer Agent Administered within the Last 14 Days of Life

(Lower Score = Better)

1/1/25 - 12/31/25, n = 2,879

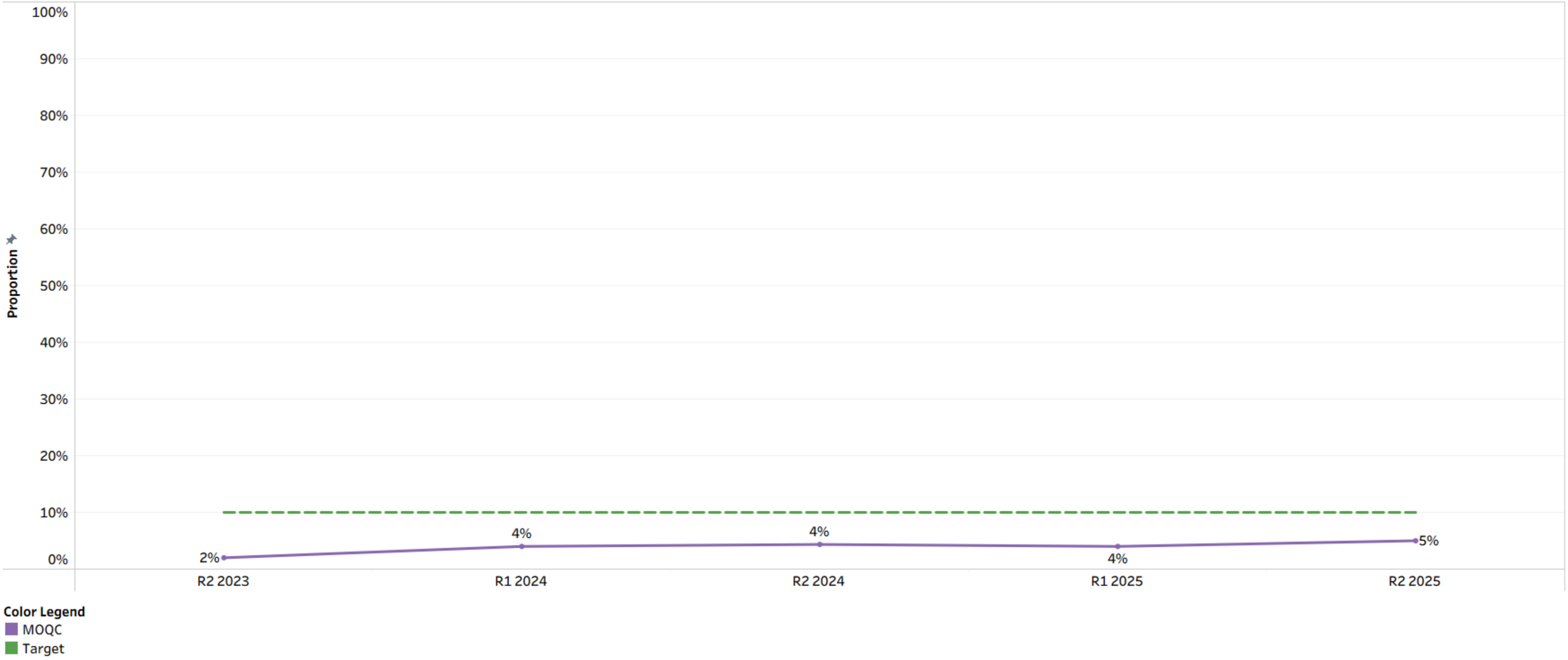


Patients with hematologic malignancies excluded.

Performance Compared to Prior Year

No Significant Change

128: Non-Chemotherapy Anticancer Agent Administered within the Last 14 Days of Life (Lower Score = Better)

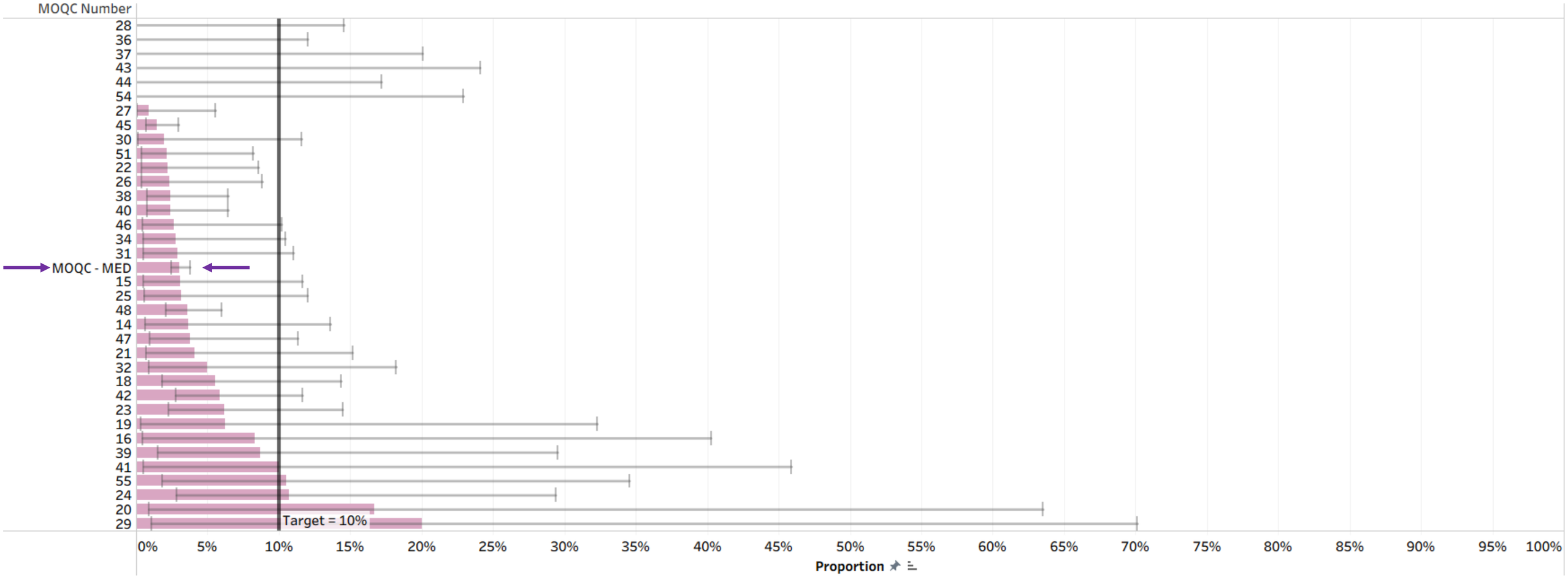


MEQC Measure

130: Beginning a New Anticancer Regimen within the Last 14 Days of Life

(Lower Score = Better)

1/1/25 - 12/31/25, n = 2,859



Patients with hematologic malignancies excluded.

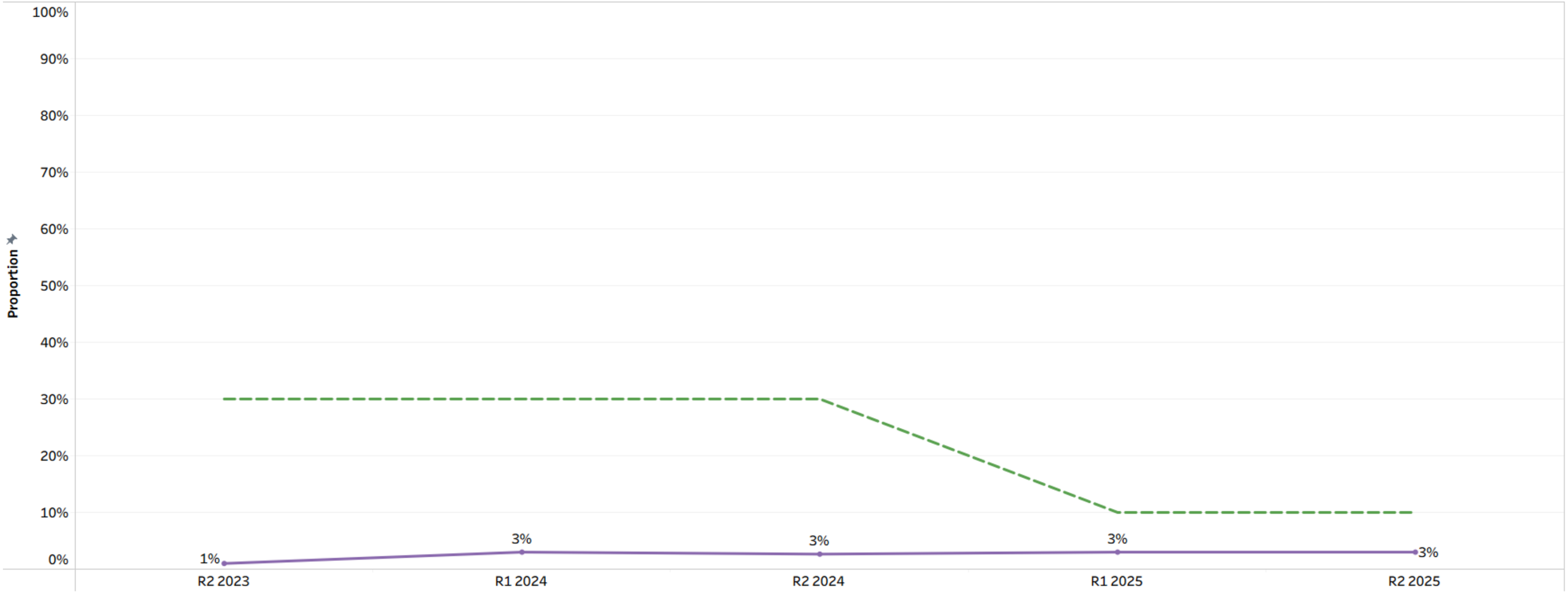
Patients receiving a new anticancer drug/regimen as part of a clinical trial excluded.

Performance Compared to Prior Year

No Significant Change

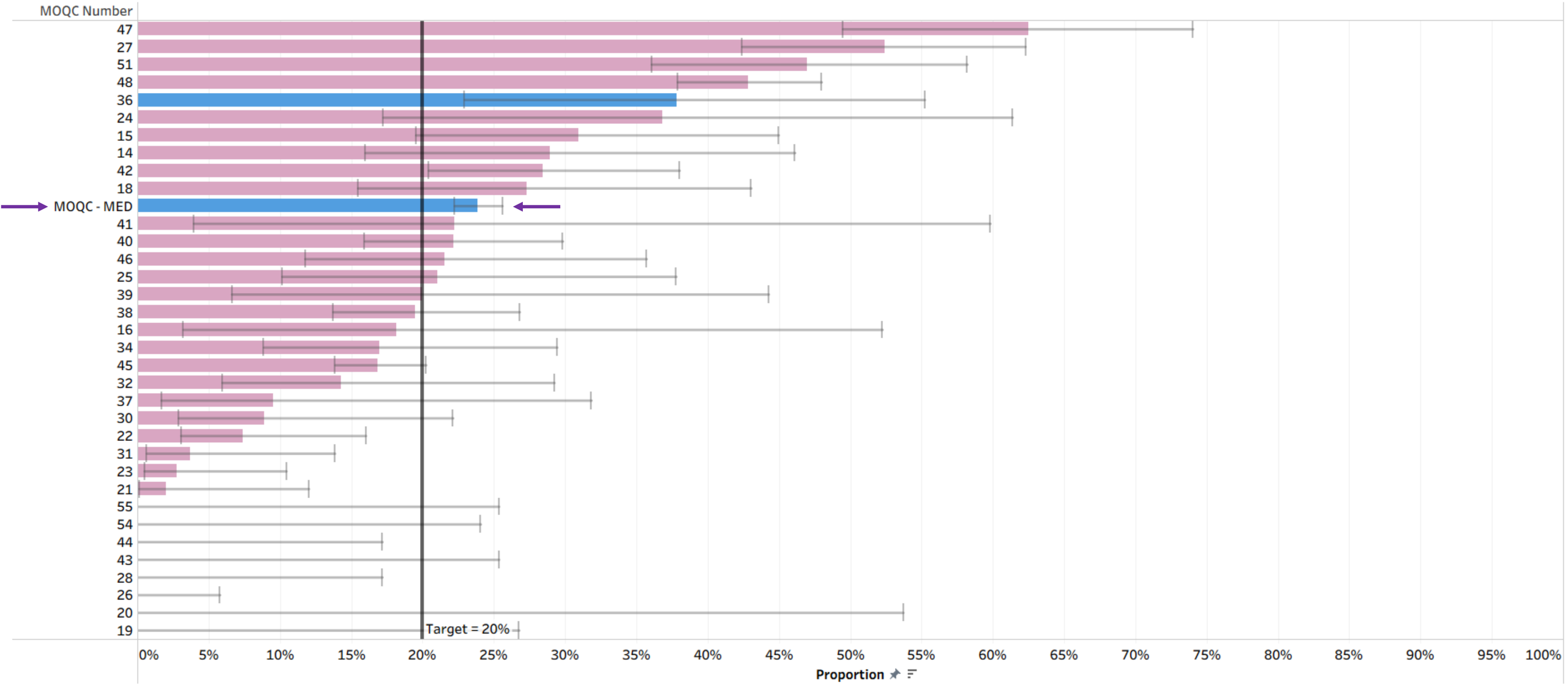
MEQC Measure

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



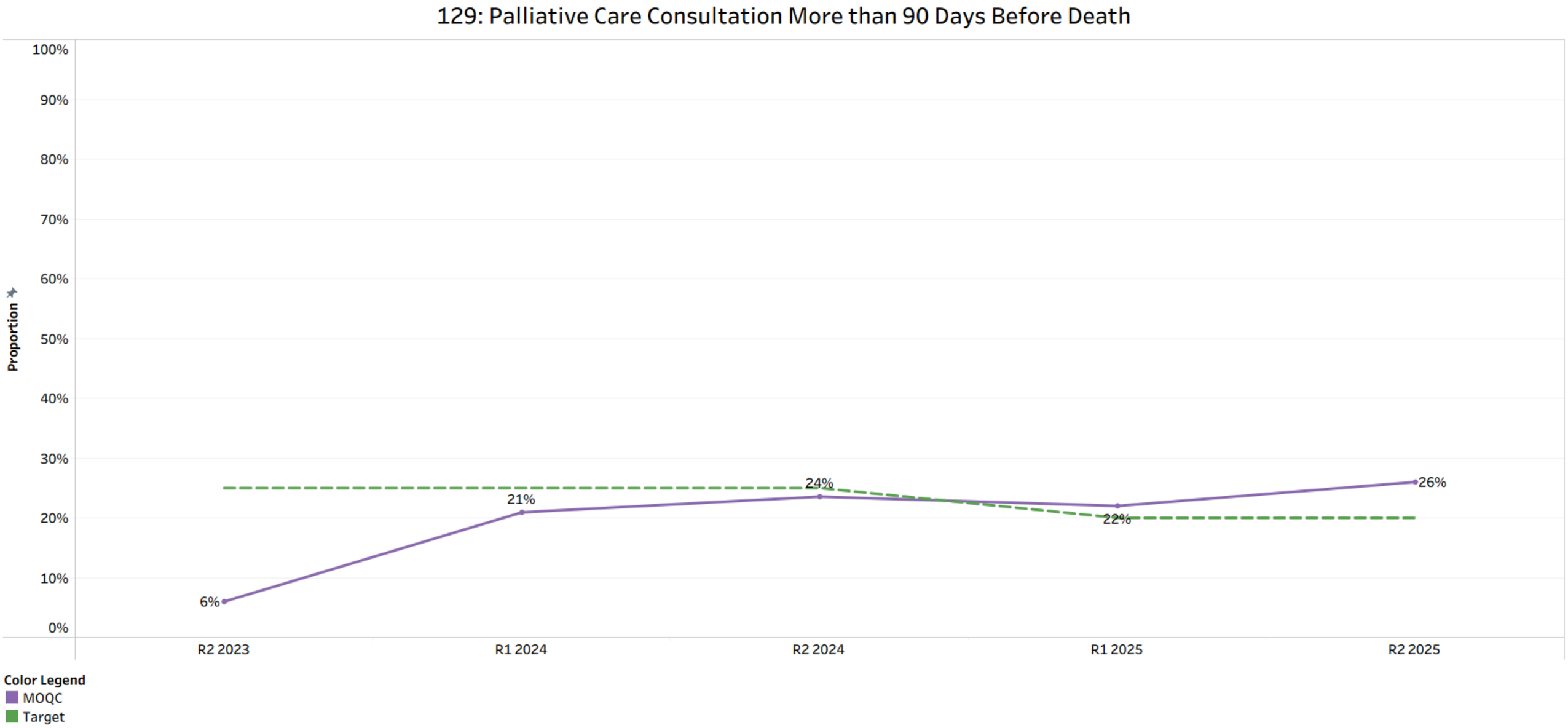
MEQC Measure

129: Palliative Care Consultation More than 90 Days Before Death
1/1/25 - 12/31/25, n = 2,551



Performance Compared to Prior Year
- No Significant Change
- Improved

MEQC Measure



Looking for Relief While Going Through Cancer?

Palliative care can help at any stage of your journey.

What is Palliative Care?

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

Is Palliative and Hospice Care the Same?

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

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

What is the Difference Between Palliative Care and Hospice?

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

How Can Palliative Care Improve My Life?

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

Physical Needs

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

Emotional Needs

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

Social Needs

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

Spiritual Needs

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

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Palliative Care Certificate Program: Cohort 2

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

Application open Jan 6-23, 2026 to

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

capc Center to Advance Palliative Care™ MOQC MICHIGAN ONCOLOGY QUALITY CONSORTIUM Blue Cross Blue Shield of Michigan

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

PROGRAM HIGHLIGHTS:

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

IMPORTANT 2026 DATES:

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

March 19

Virtual Clinical Discussions (6-7pm EST):

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

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

2026 Virtual Training Schedule

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

Application deadline January 23, 2026

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

Questions? moqc@moqc.org

End-of-Life Measures Takeaways

- **Hospice Enrollment**
  - All three hospice measures (126a, 126b, 126c) have remained stable since 2024
- **Anticancer Therapy at End of Life**
  - MOQC is meeting targets for anticancer therapy administered at end of life (127a and 128)
  - Performance for new anticancer therapy agents at end of life (130) remains very strong
- **Palliative Care**
  - Performance on palliative care consultation (129) improving across MOQC

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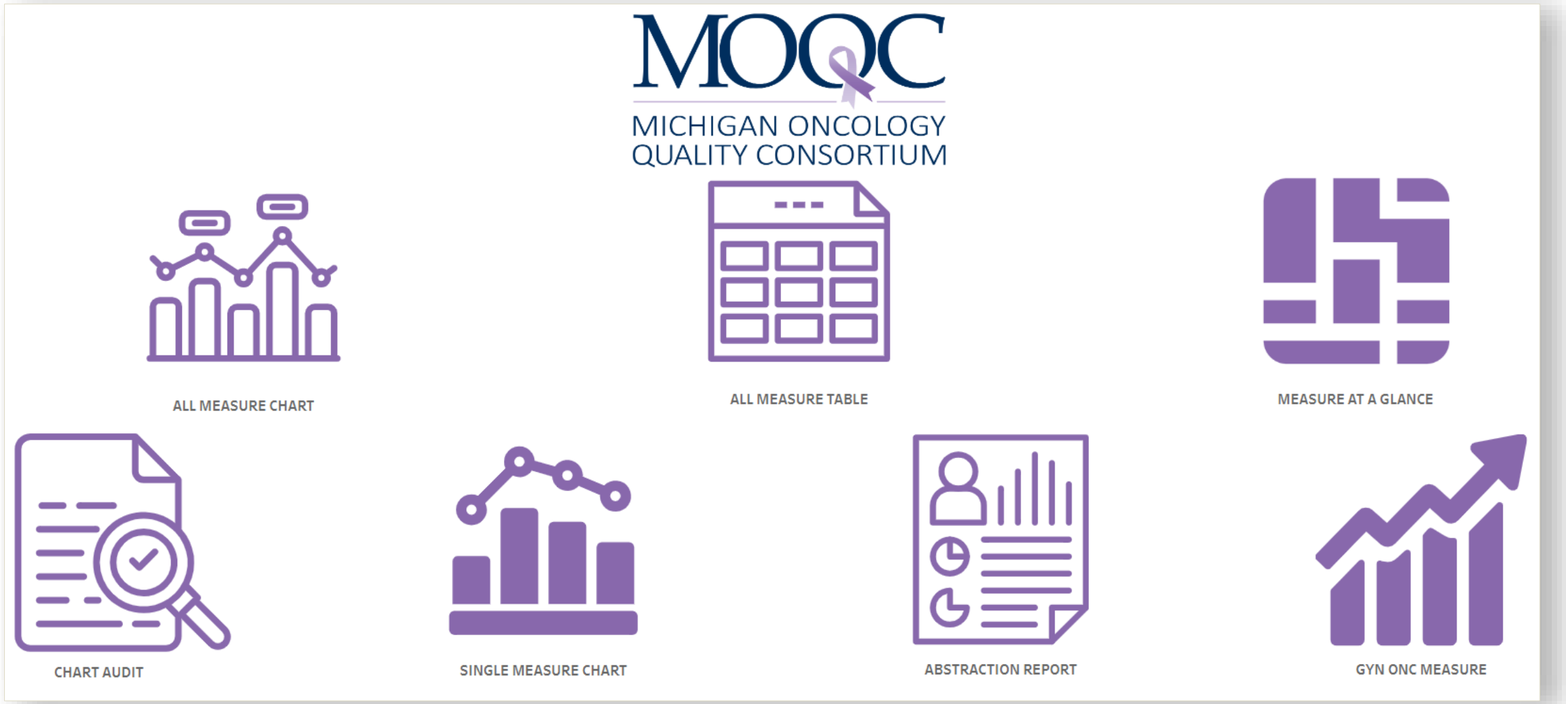
DISCUSSION

MOQC Dashboards

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



To request a dashboard account contact moqc@moqc.org

Introducing 2026 VBR & MEQC Measures

MICHIGAN ONCOLOGY QUALITY CONSORTIUM

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

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

Tobacco Measure

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

Standard VBR: 2%; scored at COLLABORATIVE level

Tobacco Measure Update

Update coming to Tobacco Cessation measure in 2027:

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