MOQC·NEWS

MICHIGAN ONCOLOGY QUALITY CONSORTIUM FALL 2017

Notes from the Program Directors

Dr. Jennifer Griggs
Program Director

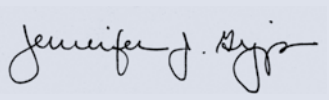
Many of the practices in the Michigan Oncology Quality Consortium serve rural populations, and some serve what are called "remote rural" populations, in which services such as dental care, mental health care services, and other fundamental health care needs are hard to find. The vast majority of the state of Michigan is rural, with a population density of fewer than 200 people per square mile. In the United States, over 70% of the land area is classified as rural, so our state is certainly not unique. Data published in July (Henley et al., MMWR Surveillance Summaries 2017 Jul 7;66(14):1-13.) indicates that for many cancers, incidence is lower but case-fatality is higher. This is due in part to lower rates of screening, later stage at presentation, and decreased access to care, particularly well-coordinated multimodality care. For some cancers, including lung, colorectal, and cervical cancers, the incidence in rural areas is higher. This finding may be explained by higher rates of tobacco use and lower rates of recommended leisure activity in rural areas.

One of the rural practices in MOQC, Mackinac Straits Oncology Services, is highlighted in this edition of our newsletter. Dr. Ed Smith hosted me and Jennifer Yanchula, MOQC's Outreach Coordinator, as we visited the three sites where he cares for patients in extremely remote sites in the Upper Peninsula. While patients enjoy the beauty of the UP, they have to travel up to five hours each way to receive radiation therapy, and rely on complete strangers for transportation. They often have to travel as far as southeast Michigan for specialized surgery, and may not be able to find mental health support or other ancillary services. While not a single patient offered a complaint to us because they all receive outstanding care with Dr. Smith, we know that not all patients in rural locales have an oncologist willing to travel sometimes treacherous roads through all four seasons to provide such care.

Our newly-formed Patient and Caregiver Oncology Quality Council has made delivering high quality cancer care for all patients one of its missions. While we often think of racial disparities when we think of addressing health inequalities, it is important to broaden our concept of disparities among rural populations, older people, people with comorbid conditions, people who live in lower socioeconomic strata, people who are obese, and sexual and gender minorities. The American Society of Clinical Oncology recently published a Position Paper on addressing cancer health disparities on sexual and gender minorities. See the next page for information on how MOQC can help your practice take the first step to create safe spaces for LGBT patients.

Finally, we look forward to seeing you at the fall Regional meetings. Each Region will be selecting one quality area on which to focus, sharing ideas to improve performance, and, as always, enjoying a meal together.

See you soon.



Dr. Shitanshu Uppal
Program Co-Director

We are excited to announce that MOQC is launching a new quality project in Spring 2018 regarding the care of gynecologic oncology patients. Currently, Michigan does not have a state-wide structure to provide feedback to practices or individual providers on the quality of ovarian cancer care. It's time to establish a quality project to fill this gap for women with ovarian cancer receiving their care in Michigan. We are seeking oncologists (both medical and gynecologic) and clinical personnel who are interested in being active in a state-wide group committed to improving care delivered to gynecological-oncology patients. We will identify and develop specific quality measures, establish an approach to data abstraction and reporting, and develop practice support strategies (e.g. best practices, tools) to improve the delivery of care for gynecologic-oncology patients.

IN THIS ISSUE

Spotlight

Providing Care in Rural and Remote Areas

An Interview with Dr. Ed Smith by Jennifer Yanchula

Q: How long have you been practicing Oncology?

A: I have been practicing oncology and hematology for 19 years. After completing my residency in Internal Medicine I had to work three years in an underserved area to fulfill a National Health Service Corp obligation. Fortunately for me there was an opportunity to do that in St. Ignace. During my nine years of practicing primary care in St. Ignace one of the frustrations for me was seeing the distance and time people had to travel for cancer and hematology care, and in some instances chose not to take treatment for those reasons. After 9 years as a primary care physician I had contemplated pursuing more specialized training and out of the blue opportunity knocked. The University of Michigan had an unexpected opening in their Hematology/Oncology Fellowship Program and I am fortunate and grateful for the privilege of joining them. My goal from day one was to return to Eastern Upper Peninsula and bring cancer care closer to home.

Q: What do you think would surprise people about cancer care in rural and remote areas?

A: I think that physicians and staff in urban and academic centers would be surprised at the lack of support services available locally for oncology patients in rural areas. Services like nutrition counseling, a psychologist evaluation, fertility and genetic counseling are not available in the area. Patients often must travel several hours for pain management, radiation therapy, thoracic surgery and infectious disease services to name a few. There is also a great need for dental services for our patients, we just do not have enough dentists and it can be difficult

continued on page 6

Sexual and Gender Minorities with Cancer and Their Loved Ones

Patients who identify as members of the LGBTQI community—most precisely and inclusively referred to as "sexual and gender minorities," are at risk of poorer cancer outcomes. Contributions to these poorer outcomes include lower rates of screening, lifelong discrimination by the healthcare system, isolation from families of choice when hospitalized or at the end of life, and lack of research on issues specific to their needs.

The American Society of Clinical Oncology recently published the "American Society of Clinical Oncology Position Statement: Strategies for Reducing Cancer Health Disparities Among Sexual and Gender Minority Populations." The statement addressing the most salient issues faced by patients and caregivers, policy maker, and researchers face in the current era. The full statement can be found at this link: **ascopubs.org/doi/abs/10.1200/JCO.2016.72.0441**

One way to demonstrate that your practice is a "safe" place for sexual and gender minorities is to display the rainbow flag. Many practices already do so. MOQC now has window/door decals available for all practices to use to display their association. These will be available at all MOQC-sponsored meetings in fall 2017. The decal is available with or without the LGBT flag. Displaying these decals is a perfect reason to update your physicians and staff about MOQC and to provide a review of your practices' policies and procedures regarding sexual and gender minorities.

The National LGBT Health Education Center provides educational programs, resources, and consultation to health care organizations with the goal of optimizing quality, cost-effective health care for sexual and gender minorities. The Education Center is a part of The Fenway Institute, the research, training, and health policy division of Fenway Health, a Federally Qualified Health Center, and one of the world's largest LGBT-focused health centers. Webinars are free and are current with today's understanding of this community. Go to **lgbthealtheducation.org** and look under the tab "Education."

Please visit **moqc.org** for resources that are practical and helpful for your practice to use and integrate into workflow related to this area of care.

BCBSM Blogs About the Collaborative Quality Initiatives (CQI)

See what BCBSM is saying about MOQC and other Collaboratives on their new Blog. This is located on BCBSM's Value Partnership landing page. See this link for more information:

www.valuepartnerships.com/vp-blog/blue-cross-cqis-gaining-national-attention

Fall 2017 MOQC Practice Registration and QOPI Round Registration OPEN

The QOPI® platform opened on August 12th for all MOQC practices to sign in and re-register their practice for Fall data abstraction. If you have not done this, please contact **lbedard@moqc.org** for step-by-step instructions. This is a required step before you can register your practice to submit data for the Fall Round.

For Fall 2017, all MOQC practices will select the MOQC Pathway for abstraction. THIS IS NEW and all MOQC practices will abstract against this Pathway for the first time in Fall, 2017. Practices exempt from this requirement are those who are abstracting for QOPI® certification or re-certification.

Practices began abstraction on **Tuesday September 12th. The Round will close Tuesday November 7th, 2017 at 5pm EST.**

Make sure that you have notified or responded to MOQC regarding your data abstraction needs. If you are reading this and you and MOQC have not communicated, please take one minute to send us an email at **lbedard@moqc.org** to ensure that your data abstraction requirements are covered.

Send your abstractors to **www.moqc.org** for the dates and times for abstraction resources. This is ***critical*** as new measures will be abstracted for the first time by staff and it will be important that there is an understanding of the measure and its components.

Standardization of Consent

The Centers for Medicare and Medicaid Services (CMS) and Michigan State Department of Health and Human Services have provided interpretive guidelines and recommendations for elements in treatment consents to ensure informed decision-making and facilitate provider-patient discussion. The American Society of Clinical Oncology (ASCO) also has guidelines for consent.

All practices educate patients and caregivers about chemotherapy treatment, its side effects and alternatives; however, developing a consent form and standardize the consenting process is dependent on various factors, including resources available to the practice.

MOQC is piloting an initiative to standardize the consent, and is using the Breast CA – Adriamycin/Cyclophosphamide/Taxol (AC-T) regimen and Lung CA Carboplatin-Taxol (CT) regimen to pilot the consent form. This is to help develop a comprehensive document that incorporates research findings on adult learning, and supports the efficient dialogue between patient and provider. We hope to have a draft of these consent forms for practices to review in mid-November.

There has been excellent feedback and response from all MOQC practices for this initiative. Practices have provided current consent forms for help with this project, and we thank you for that. If you or anyone from your team would like to be a part of the consent drafting committee, contact Arthi Ramakrishnan at **Aramakrishnan@moqc.org**.

WELCOME

Samkeliso Beusterien, MS, CCRP, CCRA
Project Manager

Sam received her Master's degree in Clinical Research Administration from Eastern Michigan University. She has over 10 years of research experience, with a focus in project management, site management, and site monitoring. As a site manager and site monitor at a multi-center clinical trial network focusing on neurological emergencies (such as stroke, TIA, and TBI), she worked with participating research sites to meet and maintain compliance with trial protocols, Good Clinical Practices, institutional and NIH polices, and FDA guidelines. Prior to joining MOQC in September 2017, Sam worked as a project manager for an NINDS-funded program designed to help investigators develop scientifically rigorous and practical clinical trials.

MOQC Team

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Final Push: Reporting 2017 Data to Medicare for Quality Payment Program (QPP/MIPS)

ASCO's webinar series is available online and covers scoring quality measures, scoring for Improvement Activities (IA) and Advancing Care Initiatives (ACI), and optimizing MIPS scores. QOPI (Quality Oncology Physician Initiative) is supporting any MOQC practice if they choose to use the QOPI platform to report their information to Medicare. For this year, there is a minimal ($<100 fee). Reach out to the QOPI help desk at ASCO at **qopi@asco.org** or 571.483.1660 for more information.

Medicare's QPP and Electronic Health Records in Practices – Re-weighting of Categories Available

Certified electronic health record technology (CEHRT) is required for participation in the advancing care information performance category of the Quality Payment Program (QPP). Under Merit-based Incentive Payment System (MIPS) scoring, MIPS-eligible clinicians and groups may qualify for a reweighting of their advancing care information performance category score to 0 percent of the final score if they meet the criteria outlined below. The 25 percent weighting of the advancing care information performance category would be reallocated to the quality performance category. Simply lacking CEHRT does not qualify the MIPS-eligible clinician or group for reweighting.

A MIPS-eligible clinician or group may submit a Quality Payment Program Hardship Exception Application, citing one of the following specified reasons for review and approval:

- Insufficient Internet Connectivity
- Extreme and Uncontrollable Circumstances
- Lack of Control over the availability of CEHRT

A group's advancing care information performance category score is automatically reweighted, (or exempted in the case of groups participating in a MIPS Alternative Payment Model (APM)), and the group would not need to submit a Quality Payment Program Advancing Care Information Hardship Exception Application if all of their MIPS-eligible clinicians within the group receive a hardship exception or fall into one or more of the Special Status categories (see website), with the exception of a non-patient facing group which only requires that 75 percent of clinicians are non-patient facing.

A group is automatically reweighted (or exempted) and does not need to submit a Quality Payment Program Hardship Exception Application if it is non-patient facing. Groups are considered non-patient facing if more than 75 percent of its clinicians have 100 or fewer patient-facing encounters (including Medicare telehealth services). If all of the MIPS-eligible clinicians within a group do not qualify for an automatic reweighting or do not submit an application for and receive a hardship exception, the group will not qualify for an automatic reweighting and will have to report on the advancing care information performance category.

To access the QPP Hardship Exception application, go to **https://qpp.cms.gov/about/hardship-exception**

For any MOQC practice that has 15 or fewer clinicians, Medicare is providing free support regarding QPP. Priority is given to those small practices:

- Located in a rural area
- Located in designated health professional shortage areas (HPSAs)
- Located in designated medically underserved areas (MUAs)

Through this initiative, practices can receive:

- Help choosing and reporting on quality measures
- Direct education and outreach. Guidance with all aspects of the program, including strategic planning and helping your team adapt to the new Quality Payment Program processes
- Support for optimizing health information technology, such as Certified Electronic Health Record Technology (CERHT)

For the State of Michigan, the contact for MOQC practices is:
Bruce Maki, M-CEITA Regulatory Analyst and Program Manager
ALTARUM INSTITUTE
734-302-474[illegible]
altarum.org

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THANKS

OCTET

A big THANK YOU to all the sites and your teams for your efforts and diligence with data collection. We are moving at a good pace and are excited to see the progression of the study. We understand that the infusion clinics are busy and are very appreciative of your diligence and efforts with data collection.

The OCTET Team recruited interested practices and academic institutions within MOQC and outside of the State of Michigan. As of Sept 30, 2017, 40 sites are participating in the study; 29 of those are MOQC sites. Of these, 26 MOQC sites have completed data collection and 2 are in their 6-week timeline doing the data collection. 1 MOQC site will participate in data collection later this year. There are 11 OCTET participating sites outside of the State of Michigan; 2 of those are doing data collection, and the rest are expected to start later this year.

If you have any questions or have a chemo infusion site that would like to participate in the study, do not hesitate to reach the OCTET Team at octet-study@umich.edu

MOQC Pathway to Be Abstracted for Fall 2017

Great News! MOQC has been working with QOPI® to allow all MOQC practices to abstract data against measures that MOQC physicians and practices have identified as important. This group of measures has been named the MOQC Pathway. It includes 17 QOPI measures and spans six modules. Four of these measures are value based reimbursement measures for MOQC practices with BCBSM. This condensed set of measures will be abstracted for the first time in Fall 2017. This is a big change for MOQC practices, as they have normally abstracted between 40-55 measures.

Although many of these measures have been abstracted historically, there are half a dozen measures that MOQC practices will identify as new for abstraction.

Be on the look-out for several new screens in the QOPI® System as you are registering your practice. Do not ignore them, but work through the screen logically. The changes are intuitive and do not require additional information or data.

These measures will change how our practices identify charts for abstraction, and how many unique charts will need to be accessed for round completion.

For more details, see **moqc.org** or call the coordinating center at 734.232.0043.

MOQC PATHWAY AND VBR MEASURES 2017

QOPI Measure Number	Module	Name of QOPI Measure
6e	Core	Pain addressed appropriately by second office visit and during most recent office visits (defect-free measure)
38	EOL	Pain addressed appropriately(defect-free measure)
13a1	Core	Chemotherapy treatment administered to patients with metastatic solid tumor with performance status of 3, 4, or undocumented (Lower Score Better)
13oral6a	Core	Oral chemotherapy treatment monitored on visit/contact following start of therapy: medication adherence assessed
14	Core	Signed patient consent for chemotherapy
22bb	Core	Tobacco cessation counseling administered or patient referred in past year
28a	SMT	Aprepitant/fosaprepitant or netupitant prescribed with low or moderate risk emetic risk Cycle 1 chemotherapy (Lower Score Better)
33	SMT	Infertility risks discussed prior to chemotherapy with patients of reproductive age*
41	EOL	Dyspnea addressed appropriately (defect-free measure)
44	EOL	Hospice enrollment within 3 days of death (Lower Score Better)
47	EOL	Hospice enrollment, palliative care referral/services, or documented discussion (defect-free measure)
61	Breast	IV bisphosphonates or denosumab administered for breast cancer bone metastases
62a1	Breast	PET, CT, or radionuclide bone scan ordered by practice within 60 days after diagnosis to stage I, IIA, or IIB breast cancer (Lower Score Better)
62c1	Breast	Serum tumor marker surveillance ordered by practice between 30 days and 365 days after diagnosis of breast cancer in patients who received treatment with curative intent (Lower Score Better)
63	CRC	Complete family history documented for patients with invasive colorectal cancer (defect-free measure)
73	CRC	Colonoscopy before or within 6 months of curative colorectal resection or completion of primary adjuvant chemotherapy
89a	NSCLC	GCSF administered to patients who received chemotherapy for metastatic NSCLC (Lower Score Better)

Six abstracted periods: Spring 2014, Spring & Fall 2015, Spring & Fall 2016, Spring 2017
Green denotes measures that improved from aggregated (4) rounds of data; statistical comparison in process as of 6/22/2017
*Reproductive age per QOPI – Females: 18-40 years of age

Spotlight, continued

to get dental needs taken care of in a timely manner.

Q: What are the challenges that you face, as a clinician in the Upper Peninsula?

A: I would have to say coordination of care for my patients presents the greatest challenge. I am not in the same office two days in a row so follow-up can be difficult. My patients have a wide variety of cancer and hematological problems. Two of the hospitals I work at do not have a radiologist or pathologist available in house so it is impossible to review things with those physicians. Oncology care often requires input from several physician disciplines and in the case of many of my patients those physicians may be in 4 different towns. I have had to coordinate care for patients with esophageal cancer between Sault Ste. Marie, St. Ignace, Petoskey and Traverse City. I also have to mention that snow and ice can make travel to my outreach clinics a challenge or no one will believe I actually practice in the UP. Continuity of care is not always optimal, if I am not there, the ER may be the only alternative. Most of the patients I care for who need hospital admission are too sick to be admitted to Mackinac Straits Hospital in St. Ignace. We only have a very small Critical Access Hospital with limited services, and so those patients need a transfer to a larger hospital. I am very appreciative of the willingness of the physicians at McLaren Northern Michigan, War Memorial and Marquette for helping out.

Q: What are the challenges that your patients and families face?

A: My patients face many of the same issues that all cancer patients face, such as financial challenges and needing help at home. There are places in my service areas that do not have electricity, telephone, or internet. There are many places cell phones do not work or people have to drive a few miles to the top of a hill to get service. Add in a snowstorm and communication can be difficult. Having to travel to larger centers can mean extra expense for lodging, meals and fuel. There are some patients who have to drive several miles to catch a ferry and then drive another hour for even basic oncology care. Obtaining medications can be a problem as there are only a few local pharmacies and they do not always carry the needed medications and have to special order them.

Q: With all of the geographical challenges, lack of specialty care and resources, why do you continue to practice in the UP?

A: It has been my home for over half of my life. I went to college in Sault Ste. Marie, have had a home in St. Ignace for over 30 years and there is nowhere I would rather live, except maybe in March and April. The patients I care for often tell me how thankful they are for being able to get some or most of their care close to home. I hope that by offering services in three locations in the Eastern Upper Peninsula, there is not anyone declining treatment for cancer because they do not want to travel. Thanks to the cooperation I have had from physicians at Major Cancer Centers, I have been able to accomplish more for cancer care delivery in the Eastern Upper Peninsula than I ever dreamed possible when I went to the University of Michigan 22 years ago.

My St Ignace staff left to right: Kristen Werner, MA, Debbie Griffin, NP, Lisa Krause, RN, Alicia Duarte, RN

Regional Work Sessions Have Begun!

Superior West gathers to identify barriers to accessing Hospice care.



Superior East works together to define the content of a standardized chemotherapy consent.



Go to **MOQC.org/events** to register for your Regional Meeting.

POQC is off to a Great Start

The Patient and Caregiver Oncology Quality Council (POQC) provides the patient and caregiver perspective for all of MOQC's activities, guides the development of new projects, and supports the MOQC Steering Committee and MOQC practices. The first conference call was in April of this year and they have hit the ground running. The group has already provided their review and feedback regarding oral chemotherapy teaching sheets and Tobacco Cessation materials. All POQC members are encouraged to attend the Regional meeting near them and the two Biannual meetings as well. POQC is currently made up of 15 patients and caregivers from around the state of Michigan. We have representation from Allen Park, Ann Arbor, Houghton (UP), Ionia, Isabella, Morrice, Petoskey, St Clair Shores, Sterling Heights, Taylor, and Waterford. We hope to continue growing this council until it represents every Region. If you have any questions or would like to refer a patient or caregiver from your area, please contact Jennifer Yanchula at **jyanchula@moqc.org**

QUESTIONS?

Call us at 866-438-6672
(866-GET-MOQC)
or email us via our website
moqc.org/contact-us

MOQC Participation Agreements Due October 31, 2017

For those that have not submitted a signed participation agreement, you should have received via email a pre-filled participation agreement from MOQC for signature. If you do not remember this, please contact us at **lbedard@moqc.org**. If you have completed the pre-filled participation agreement, please return it to MOQC by **October 31, 2017**. For those practices that have completed this activity, thank you very much! Your turnaround on this important requirement has been most appreciated by the Coordinating Center Team.

MOQC
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QUALITY CONSORTIUM

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UPCOMING EVENTS

November 7 • 6:00 – 8:00 pm
Metro East Regional Meeting (ME)
Detroit Marriott Troy
200 West Big Beaver Road
Troy, MI 48084

November 9 • 6:00 – 8:00 pm
Lake Michigan Oncology (LMOR)
East Lansing Marriott
300 M.A.C. Avenue
East Lansing, MI 48823

November 15 • 6:00 – 8:00 pm
West of Woodward (WOW)
North Campus Research Center
2800 Plymouth Road
Ann Arbor, Michigan 48109

November 16 • 6:00 – 8:00 pm
Central Michigan (CMG)
Hampton Inn, 12130 Tiffany Blvd
Birch Run, Michigan 48415

January 19, 2018• 10:00 am – 4:00 pm
January 2018 Biannual Meeting
The Inn at St. John's, 44045 Five Mile
Plymouth, MI 48170

June 22, 2018 • 10:00 am – 4:00 pm
June 2018 Biannual Meeting
Location TBD: Grand Rapids area

View complete calendar of events:
www.moqc.org/news&events

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