MR QC

MICHIGAN RADIATION ONCOLOGY QUALITY CONSORTIUM

WELCOME

May 15, 2026

Slides

- The slides for today's presentations will be made available to all MROQC members via our website next week

Issues

- Issues during the meeting? Please let a Coordinating Center Team member know!

MEETING HOUSEKEEPING

SOCIAL MEDIA

Join the conversation on by tagging @MROQC and using our #MROQC25CWM hashtag

TODAY'S AGENDA

Radiation Oncology Billing Updates: Addressing Facility Challenges & Expert Q&A

ASTRO DVH Constraints: Performance Insights & Implications for Future Quality Measures

State of MROQC

Breakouts

BREAKOUT AGENDAS

Physicians/Administrators:
- Billing Issues
- 2027 Quality Measures

CDAs:
- Introduction to Brain Mets with Dr. Edwards
- CDA Calendar Dashboard Demo

Physics/Dosimetry:
- ASTRO DVH Constraints
- Prostate MRI Submission Pilot
- Brain Mets Physics Data Collection

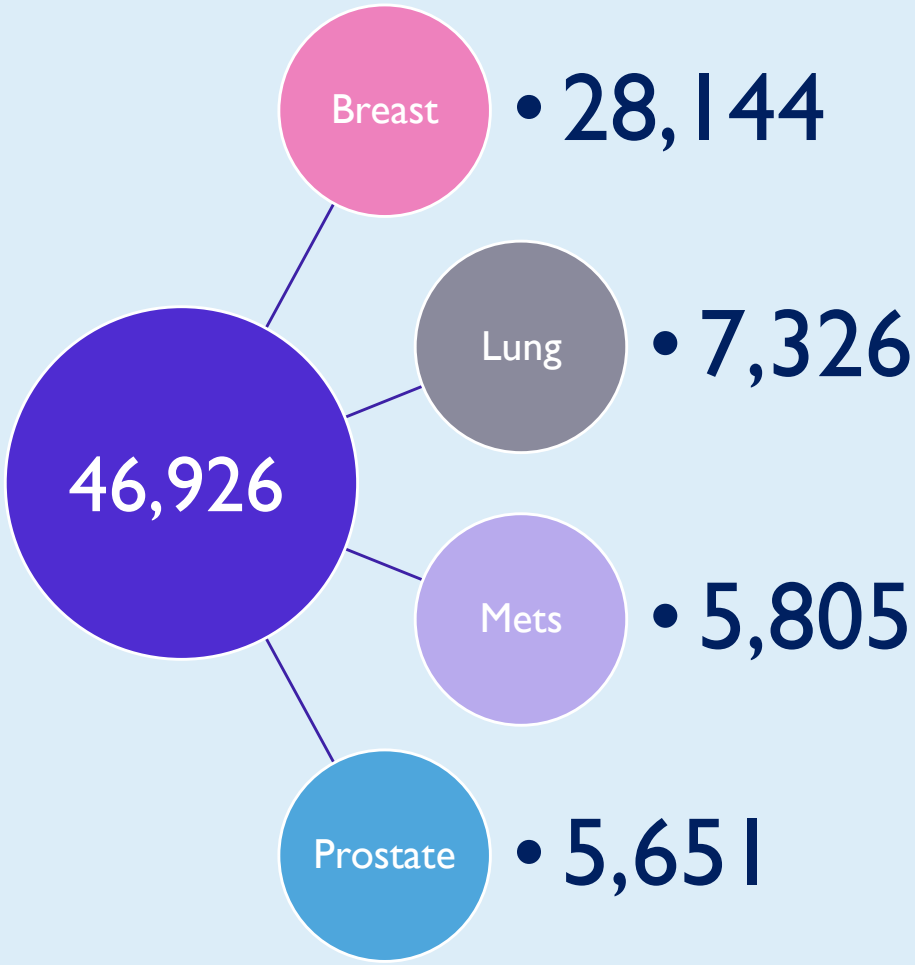
MROQC BY THE NUMBERS

MROQC TODAY

- Brighton Center for Specialty Care-*Brighton*
- Covenant HealthCare-*Saginaw*
- Henry Ford Jackson–*Jackson*
- Henry Ford Macomb Hospital-*Clinton Twp.*
- Henry Ford Providence Hospital–*Southfield & Novi*
- Henry Ford St. John Hospital–*Detroit*
- Henry Ford Warren Hospital–*Warren*
- Genesys Hurley Cancer Institute–*Flint*
- Karmanos Cancer Institute–*Detroit*
- McLaren Bay Region-*Bay City*
- McLaren Central-*Mt. Pleasant*
- McLaren Greater Lansing-*Lansing*
- McLaren Flint–*Flint & Lapeer*

- McLaren Macomb-*Mount Clemens & Clarkston*
- McLaren Northern Hospital–*Petoskey*
- Michigan Health Professionals*(6 locations)*
- Michigan Medicine-*Ann Arbor*
- MyMichigan Medical Center-*Midland*
- MyMichigan Medical Center-*Alpena*
- MyMichigan Medical Center-Saginaw *
- MyMichigan Medical Center-*West Branch* *
- Munson Medical Center–*Traverse City*
- University of Michigan Health-Sparrow–*Lansing*
- Trinity Health Muskegon Hospital-*Muskegon*
- Trinity Health Saint Mary's-*Grand Rapids*
- University of Michigan Health West-*Grand Rapids*
- West Michigan Cancer Center-*Kalamazoo*

MROQC By The Numbers



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As of May 1, 2026

Revised Treatment Delivery Codes

May 15, 2026

ASTRO
AMERICAN SOCIETY FOR RADIATION ONCOLOGY

Questions

Please continue reporting issues to healthpolicy1@astro.org

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ASTRO DVH CONSTRAINTS

May 15, 2026

ASTRO DVH DOSE CONSTRAINT COMPENDIUM (2025)

Overview

- ASTRO recently published a consensus compendium of DVH dose constraints for treatment planning across multiple disease sites
- Developed by disease-site expert panels using literature review and consensus methods
- Includes breast, head & neck, liver, lung, prostate, and rectal cancers

Purpose

Provide standardized dose constraints for treatment planning

Support consistent, high-quality radiation therapy delivery

Inform future quality performance indicators

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POTENTIAL OPPORTUNITY FOR MROQC

Current State

Each disease-site working group has reviewed preliminary results for ASTRO DVH constraints for specific fractionations to determine:

- Which constraints can be evaluated using existing MROQC data
- Whether any constraints could serve as future MROQC quality measures

Next Steps

Review and discuss as a large group today

Identify 1–2 potential constraints for exploratory analysis in MROQC data

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LUNG

LUNG DVH CONSTRAINTS

The compendium includes dose constraints for common lung fractionation regimens, including:

Conventional fractionation (60–70 Gy)

Moderately hypofractionated regimens

Ultrahypofractionated / SBRT regimens

Constraints include **organs at risk (OARs)** such as:

Lung (V20, V5, mean lung dose)

Esophagus

Heart

Spinal canal

Brachial plexus

Chest wall / ribs

These constraints are intended to guide **treatment planning optimization** and **reduce toxicity risk**.

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Table 11 Lung: conventionally fractionated regimens (1.8-2 Gy per fraction to 60-70 Gy)

Organ/target	Metric	Primary goal	Secondary goal	Deviation	Notes
Esophagus[2,44-47]	D0.03cc	≤105%	≤74 Gy	>74 Gy	
	V60Gy	≤15.3%*	≤17%	>17%	
	Mean	≤30.6 Gy*	≤34 Gy	>34 Gy	
Heart[2]	V45Gy	≤35%	≤40%	>40%	
Lungs[44,47,49]	V20Gy	≤33%*	≤37%	>37%	Lungs − GTV/iGTV
	V5Gy	≤60%	≤70%	>70%	
	Mean	≤18 Gy*	≤22 Gy	>22 Gy	
SpinalCanal[44,47]	D0.03cc	≤50.5 Gy	≤52 Gy	>52 Gy	
PTV[44,47]	D95%	100%	≥95%	<95%	

Abbreviations: D = dose; GTV = gross tumor volume; iGTV = internal gross target volume; PTV = planning target volume; V = volume.
*Panel consensus.

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CONVENTIONALLY FRACTIONATED (1 PLAN, 2022-PRESENT)

Organ/Target	Metric	Primary %	Secondary %	Deviation %	N
Esophagus	D0.03cc	81.9%	100.0%	0.0%	669
	V60Gy	91.8%	94.6%	5.4%	669
	Mean	96.6%	99.6%	0.4%	669
Heart	V45Gy	100.0%	100.0%	0.0%	669
Lungs	V20Gy	86.3%	98.8%	1.2%	657
	V5Gy	58.3%	85.8%	14.2%	657
	Mean	88.0%	99.7%	0.3%	657
Spinal canal	D0.03cc	99.9%	99.9%	0.1%	668
PTV	D95%	90.3%	99.0%	1.0%	659

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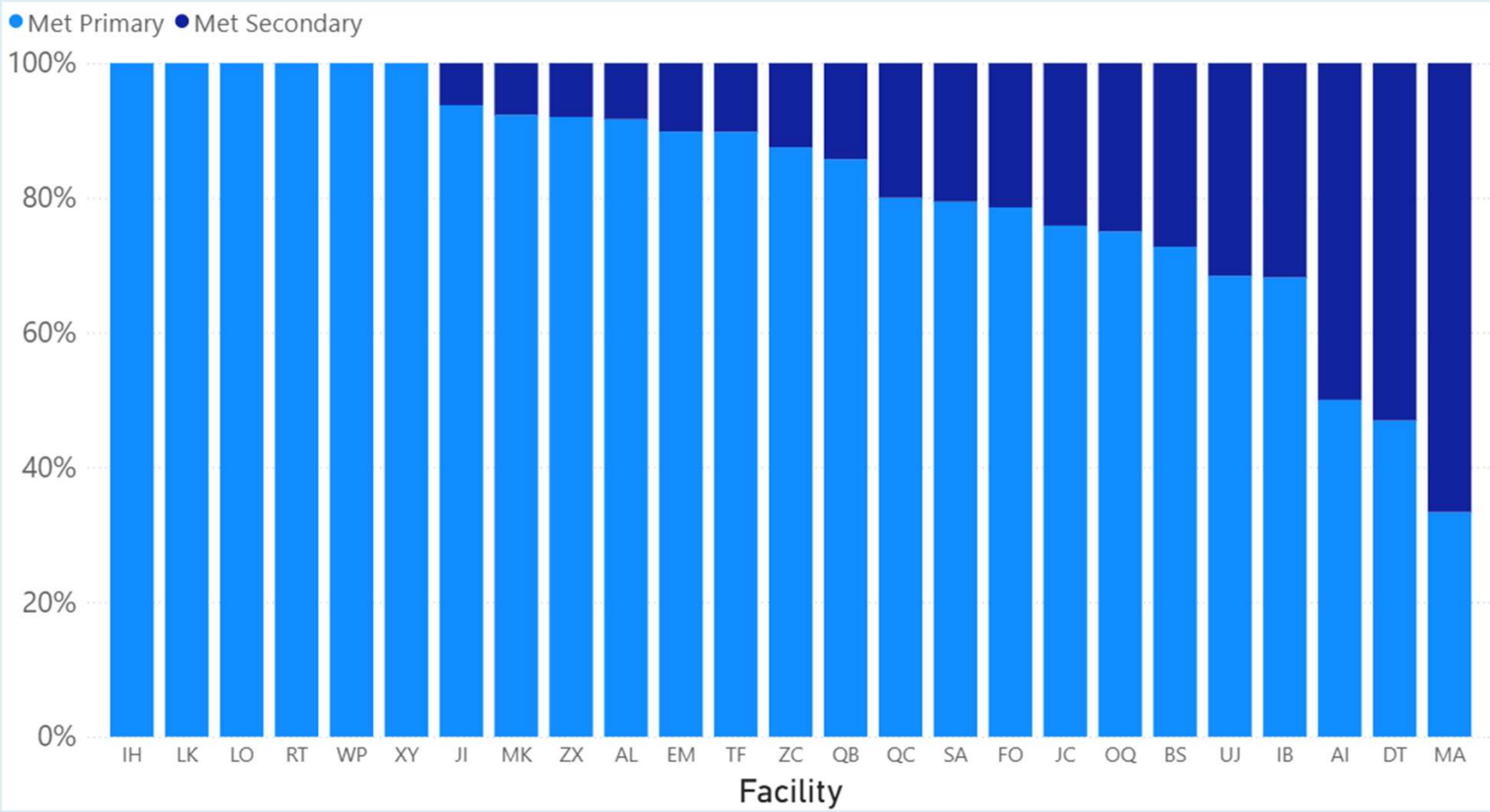
Organ/target	Metric	Primary goal	Secondary goal	Deviation
Esophagus	D0.03cc	≤105%	≤74 Gy	>74 Gy



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Organ/target	Metric	Primary goal	Secondary goal	Deviation
Esophagus	D0.03cc	≤105%	≤74 Gy	>74 Gy

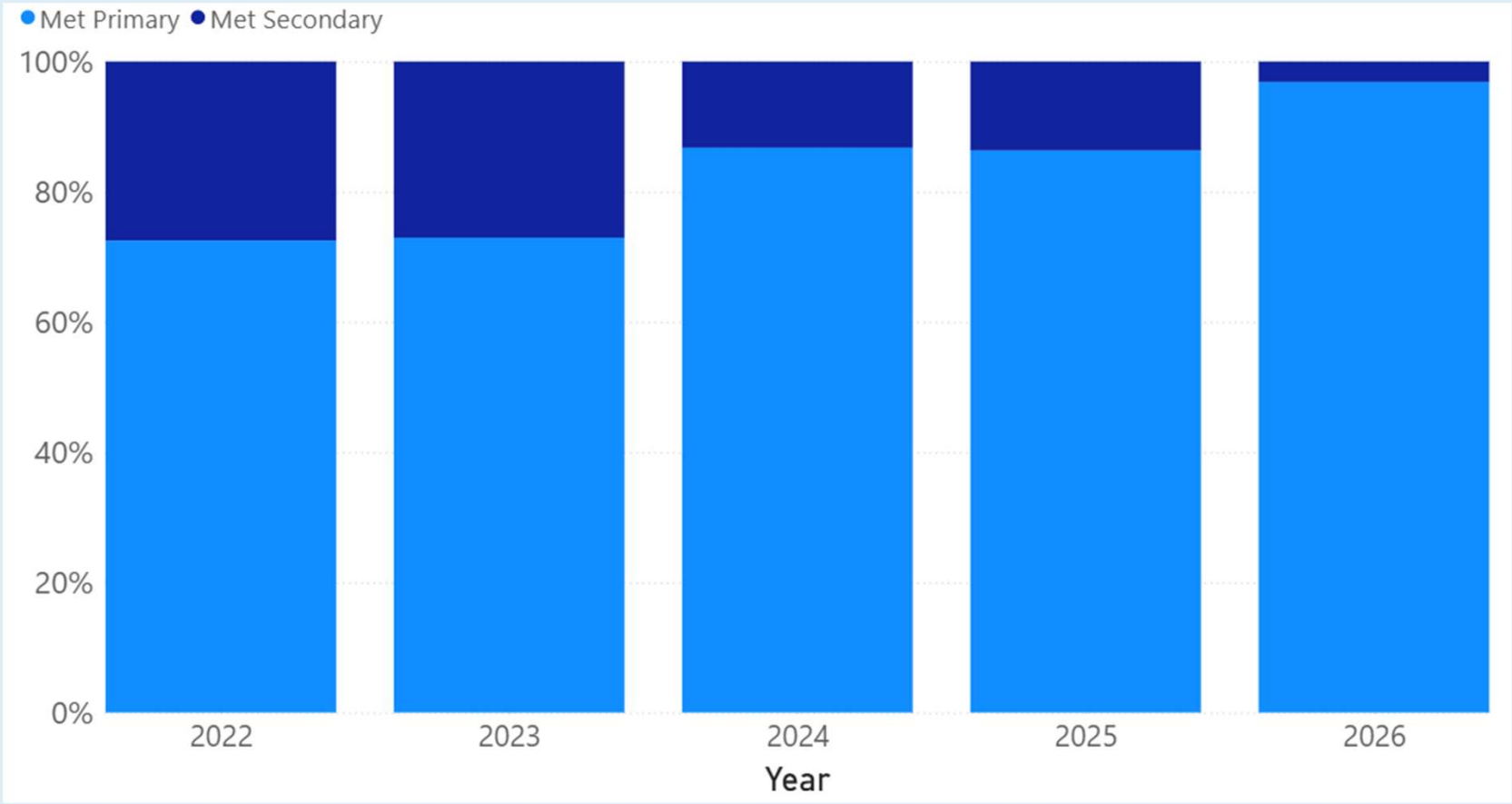

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Table 15 Lung: ultrahypofractionated 5 fraction regimens (10-12 Gy per fraction to 50-60 Gy)

Organ/target	Metric	Primary goal	Secondary goal	Deviation	Notes
BrachialPlex[39,45,54,55]	D0.035cc	≤32 Gy		>32 Gy	
Bronchus[3,5,39]	D0.035cc	≤40 Gy	≤105%	>105%	Bronchial tree/smaller airways
	D0.5cc	≤21 Gy		>21 Gy	
Chestwall[35,39,40,52]	D0.035cc	≤50 Gy*	≤57 Gy	>57 Gy	
	V30Gy	≤30 cc	≤70 cc	>70 cc	
Esophagus[3,5,39]	D0.035cc	≤38 Gy	≤105%	>105%	
	D5cc	≤19.5 Gy		>19.5 Gy	
GreatVes[39,45,55]	D0.035cc	≤105%		>105%	
Heart[3,5,39,55]	D0.035cc	≤38 Gy	≤105%	>105%	
	D15cc	≤32 Gy		>32 Gy	
Lungs[3,4,55]	V20Gy	≤10%	≤15%	>15%	Lungs − GTV/iGTV
	Mean	≤8 Gy		>8 Gy	
SpinalCanal[5,39]	D0.035cc	≤28 Gy		>28 Gy	
PTV	D95%	100%*	≥99%*	<99%*	Peripheral or central lesions
	D99%	≥90% *	≥85%*	<85%*	

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5-FRACTION SBRT (2022-PRESENT)

Organ/Target	Metric	Primary %	Secondary %	Deviation %	N
Brachial plexus	D0.035cc	99.2%	N/A	0.8%	379
Bronchus	D0.035cc	96.8%	96.8%	3.2%	251
	D0.5cc	90%	N/A	10%	251
Chest wall	D0.035cc	32.4%	69.3%	30.7%	873
	V30Gy	80.8%	97.4%	2.6%	873
Esophagus	D0.035cc	99.3%	99.3%	0.7%	1063
	D5cc	99.7%	N/A	0.3%	1063
Great vessels	D0.035cc	98.2%	N/A	1.8%	649
Heart	D0.035cc	97.4%	99.7%	0.3%	1064
	D15cc	99.9%	N/A	0.1%	1064
Normal lung	V20Gy	98.5%	99.7%	0.3%	1028
	Mean	99.5%	N/A	0.5%	1031
Spinal canal/cord	D0.035cc	100%	N/A	0%	1062
PTV	D95%	93.2%	94.3%	5.7%	1041
	D99%	95.9%	97.1%	2.9%	1041

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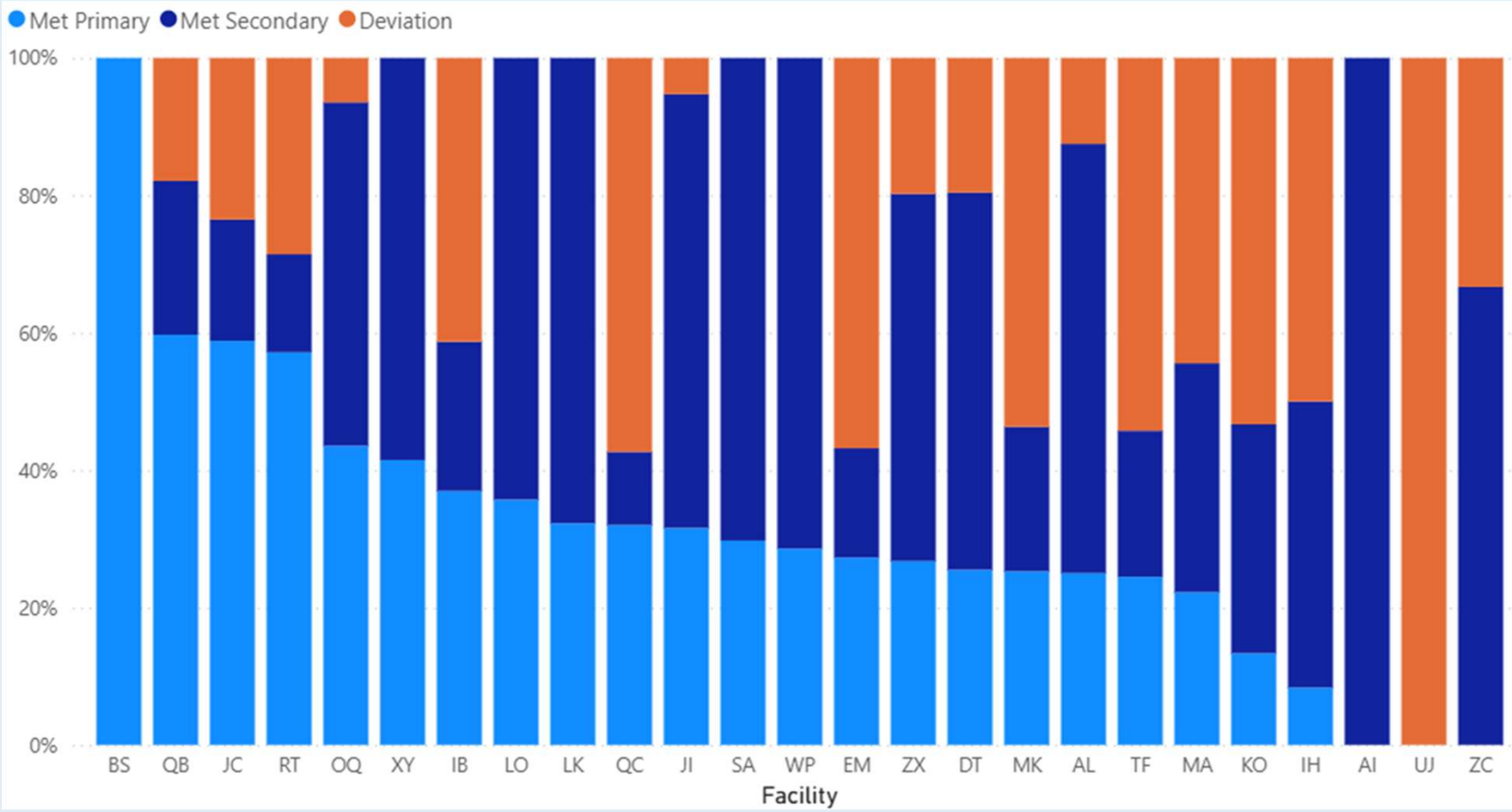
Organ/target	Metric	Primary goal	Secondary goal	Deviation
Chest wall	D0.035cc	≤50 Gy	≤57 Gy	>57 Gy



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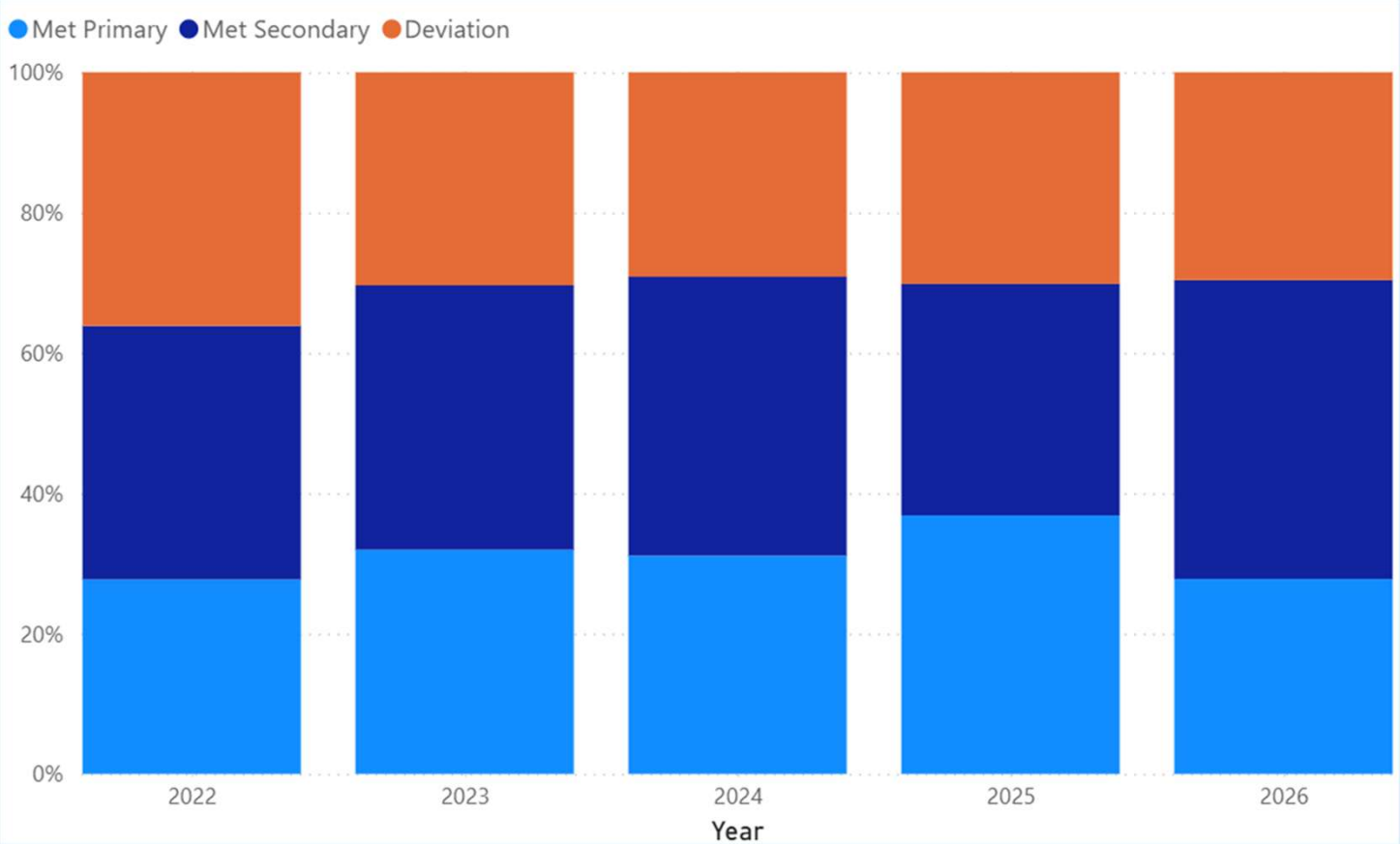
Organ/target	Metric	Primary goal	Secondary goal	Deviation
Chest wall	D0.035cc	≤50 Gy	≤57 Gy	>57 Gy



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DISCUSSION

Which DVH constraints are most clinically meaningful?

How do we view performance on constraints such as chest wall near-max dose?

What tradeoffs are involved in selection of fractionation and planning goals?

What constraints may be suitable for collaborative quality measures?

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BREAST

BREAST DVH CONSTRAINTS

The compendium includes dose constraints for common breast fractionation regimens, including:

- Conventional (with nodes)
- **Moderately hypofractionated (with nodes and without nodes)**
- Ultrahypofractionated regimens (WBI and PBI)

Constraints include targets and OARs such as:

- Breast target coverage and near max dose
- Lung volume metrics
- Heart mean dose and volume metrics
- Nodal region target coverage and near max dose

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These constraints are intended to guide **treatment planning optimization** and **reduce toxicity risk**.

Table 2 Breast/chest wall without regional lymph nodes: moderately hypofractionated 15 or 16 fraction regimens (2.66-2.67 Gy per fraction to 40.05-42.56 Gy)

Organ/target	Laterality	Metric	Primary goal	Secondary goal	Deviation	Notes
Breast (Contralateral)	Left/right	D5%	≤1.44 Gy*	≤2.4 Gy*	>2.4 Gy*	
Heart[20]	Left	Mean	≤1.6 Gy	≤2.4 Gy	>2.4 Gy*	
	Right	Mean	≤0.8 Gy	≤1.6 Gy	>1.6 Gy	
Lung[20-22]						
(Contralateral)	Left/right	V4Gy	≤10%	≤15%	>15%	
(Ipsilateral)[20,22]	Left/right	V16Gy	≤15%	≤20%	>20%	
Breast/chestwall†[19]	Left/right	Rx dose	V95% ≥95%	V90% ≥90%	V90% <90%	Field volume may substitute for contoured PTV
	Left/right	D0.03cc	≤110%*	≤115%*	>115%*	
	Left/right	V107%	≤10 cc		>10 cc	

Abbreviations: D = dose; PTV = planning target volume; Rx = prescription; V = volume.
*Panel consensus.
†Goals do not include dose contribution from a boost (eg, lumpectomy cavity boost).

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MEAN HEART DOSE METRICS (NODE NEGATIVE AWBI)

Year(s)	Target	Metric	Measure Description
2016–2018	90%	≤ 2 Gy	Mean heart dose for 90% of node-negative breast patients
2019	75%	Left ≤ 1.2 Gy Right ≤ 0.7 Gy	Mean heart dose achieved in breast patients not receiving radiotherapy to regional nodes
2020	85%		
2021	85%	Left: ≤ 1.2 Gy Right: ≤ 0.7 Gy	For node-negative breast cancer patients, ≥95% of the lumpectomy cavity PTV receives ≥95% of the whole breast prescription dose AND the heart mean dose meets threshold appropriate to laterality and fractionation
2022	80%	Left: ≤ 1 Gy	For node-negative breast cancer patients, ≥95% of the lumpectomy cavity PTV receives ≥95% of the whole breast prescription dose AND the heart mean dose is ≤ 1.0 Gy for left-sided cases receiving moderate dose hypofractionation. (Only applies for breast volumes less than 1500 cc in 2023)
2023	70%		

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MODERATELY HYPOFRACTIONATED, **WITHOUT NODES** (2022-PRESENT)

Organ/Target	Metric	Primary %	Secondary %	Deviation %	N
Heart, left	Mean	99.6	99.9	0.1	1657
Heart, right	Mean	99.5	100.0	0.0	1603
Ipsilateral lung	V16Gy	88.9	98.4	1.6	3255
Breast	Rx Dose	83.2	90.8	9.2	3180
	D0.03cc	98.6	99.9	0.1	3180
	V107%	92.6	—	7.4	3180

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Table 3 Breast/chest wall with regional lymph nodes: moderately hypofractionated 15 or 16 fraction regimens (2.66-2.67 Gy per fraction to 40.05-42.56 Gy)

Organ/target	Laterality	Metric	Primary goal	Secondary goal	Deviation	Notes
Heart[19]	Left	Mean	≤3 Gy	≤5 Gy	>5 Gy	
	Right	Mean	≤1.6 Gy*	≤2.4 Gy*	>2.4 Gy*	
Lung[19]						
(Ipsilateral)	Left/right	V18Gy	≤35%	≤40%	>40%	
	Left/right	V10Gy	≤60%*		>60%*	
Breast/Chestwall†[19]	Left/right	Rx dose	V95% ≥95%	V90% ≥90%	V90% <90%	Field volume may substitute for contoured PTV
	Left/right	D0.035cc	≤110%*	≤115%*	>115%*	
	Left/right	V107%	≤10 cc		>10 cc	
LN_Sclav[19]	Left/right	Rx dose	V95% ≥95%	V90% ≤90%	V90% <90%	
	Left/right	D0.035cc	≤110%*	≤115%*	>115%*	
LN_Ax[19]	Left/right	Rx dose	V95% ≥95%	V90% ≥90%	V90% <90%	
	Left/right	D0.035cc	≤110%*	≤115%*	>115%*	
LN_IMN[19]	Left/right	V90%	≥90%	≥80%	<80%	
	Left/right	D0.035cc	≤110%*	≤115%*	>115%*	

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MODERATELY HYPOFRACTIONATED, **WITH NODES** (2022-PRESENT)

Organ/Target	Metric	Primary %	Secondary %	Deviation %	N
Heart, left	Mean	98.2	100.0	0	109
Heart, right	Mean	98.3	100.0	0	115
Ipsilateral lung	V18Gy	95.5	100.0	0	224
	V10Gy	99.6	—	0.4	224
Breast	Rx dose	83.7	91.9	8.1	221
	D0.035cc	92.8	98.2	1.8	221
	V107%	85.5	—	14.5	221
Sclav	Rx dose	54.8	91.4	8.6	104
	D0.035cc	64.4	95.2	4.8	104
IMN	V90%	59.6	70.2	29.8	94
	D0.035cc	75.5	79.8	20.2	94

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DISCUSSION

How should we evaluate heart dose constraints from ASTRO vs. those established by MROQC?

How should we interpret results for nodal target structures?

What constraints may be suitable for collaborative quality measures?

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PROSTATE

PROSTATE DVH CONSTRAINTS

The compendium includes dose constraints for common prostate fractionation regimens, including:

Conventional fractionation (74-81 Gy)

Moderately hypofractionated regimens (20 or 28 fractions)

Ultrahypofractionated / SBRT regimens

Constraints include **organs at risk (OARs)**:

Bladder

Rectum

Others (not required by MROQC):

- Bowel_Large
- Bowel_Small
- Femur_Head
- PenileBulb
- Urethra

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These constraints are intended to guide **treatment planning optimization** and **reduce toxicity risk**.

MODERATELY HYPOFRACTIONATED (28 FRACTIONS)

Table 21 Prostate: moderately hypofractionated 28 fraction regimen (2.5 Gy per fraction to 70 Gy)

Organ/target	Metric	Primary goal	Secondary goal	Deviation	N
Bladder[65,67-69,71]	V70Gy	≤10%	≤15%	>15%	
	V65Gy	≤15%	≤25%	>25%	
	V40Gy	≤35%	≤65%	>65%	
Bowel_Large[65,68]	D0.035cc	≤55 Gy	≤60 Gy	>60 Gy	
	V50Gy	≤1%*	>1%*		
Bowel_Small[67,71]	D0.035cc	≤52.5 Gy	≤54 Gy	>54 Gy	
	V40Gy	≤1%	>1%		
Femur_Head[71]	V40Gy	0%		>0%	
PenileBulb[71]	Mean	<50 Gy		≥50 Gy	P
Rectum[67-69,71]	V70Gy	≤5%	≤10%	>10%	
	V65Gy	≤10%		>10%	
	V40Gy	≤35%		>35%	
PTV	V100%	≥95%*	≥90%*	<90%*	
	D2%	≤110%*	≤115%*	>115%*	

Abbreviations: D = dose; PTV = planning target volume; V = volume.
*Panel consensus.

Contour	Metric	Primary %	Secondary %	Deviation %	N
Bladder	V70Gy	90.6%	97.5%	2.5%	1411
	V65Gy	90.7%	98.7%	1.3%	1411
	V40Gy	75.6%	97.7%	2.3%	1411
Rectum	V70Gy	87.9%	99.0%	1.0%	1413
	V65Gy	88.4%	-	11.6%	1413
	V40Gy	85.5%	-	14.5%	1413
PTV	V100%	74.4%	95.9%	4.1%	1382
	D2%	85.6%	89.9%	10.1%	1382

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MODERATELY HYPOFRACTIONATED (20 FRACTIONS)

Table 20 Prostate: moderately hypofractionated 20 fraction regimen (3 Gy per fraction to 60 Gy)

Organ/target	Metric	Primary goal	Secondary goal	Deviation
Bladder[64,65,69]	V60Gy	≤5%	≤15%	>15%
	V48Gy	≤25%		>25%
	V40Gy	≤50%		>50%
Bowel_Large[65]	D0.03cc	≤50 Gy		>50 Gy
Bowel_Small[64,68]	D0.03cc	≤50 Gy*		>50 Gy*
	V40Gy	≤17 cc	≤195 cc	>195 cc
Femur_Head[64]	V40Gy	≤5%	≤50%	>50%
PenileBulb[64]	V48Gy	≤10%		>10%
Rectum[67,69,70]	V60Gy	≤0.01%	≤8%	>8%
	V50Gy	≤22%		>22%
	V30Gy	≤57%		>57%
PTV	V100%	≥95%*	≥90%*	<90%*
	D2%	≤110%*	≤115%*	>115%*

Abbreviations: D = dose; PTV = planning target volume; V = volume.
*Panel consensus.

Contour	Metric	Primary %	Secondary %	Deviation %	N
Bladder	V60Gy	63.3%	99.7%	0.3%	338
	V48Gy	97.6%	-	2.4%	338
	V40Gy	96.4%	-	3.6%	338
Rectum	V60Gy	2.4%	95.3%	4.7%	339
	V50Gy	99.4%	-	0.6%	339
	V30Gy	91.4%	-	8.6%	339
PTV	V100%	55.0%	86.1%	13.9%	331
	D2%	78.5%	92.4%	7.6%	331

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DISCUSSION

What is the relationship between dosimetric constraints on OARs and treatment quality?

What OAR constraints and PTV coverage goals would be better surrogates for plan quality?

How should MROQC approach target coverage goals?

What would be meaningful improvement for prostate cancer patients?

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BREAK

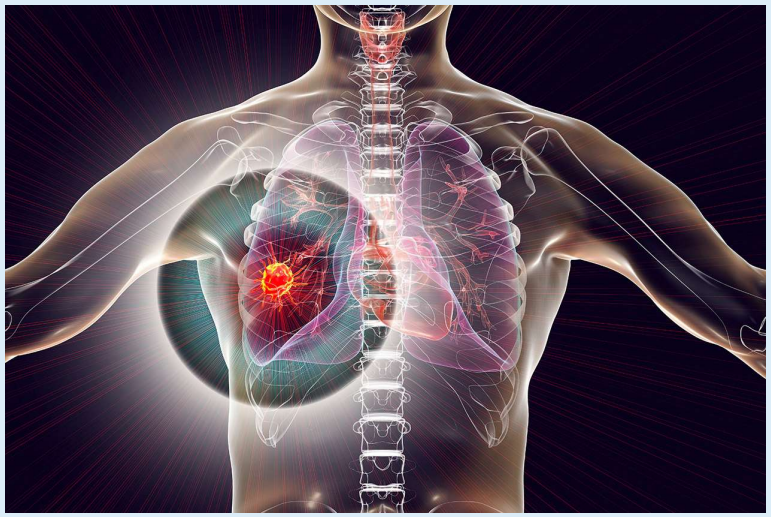
Let's take a quick break to stretch and prepare for the State of MROQC

Take 5 minutes

STATE OF MROQC

MROQC Lung Quality Improvement Working Group Update

May 15, 2026



Shruti Jolly, Garth Tormoen, Martha Matuszak

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LUNG WORKING GROUP

Today's Agenda

WORKING GROUP
STATUS UPDATES

EXPANDED TOXICITY
COLLECTION

Lung Working Group Status Updates: Enrollment

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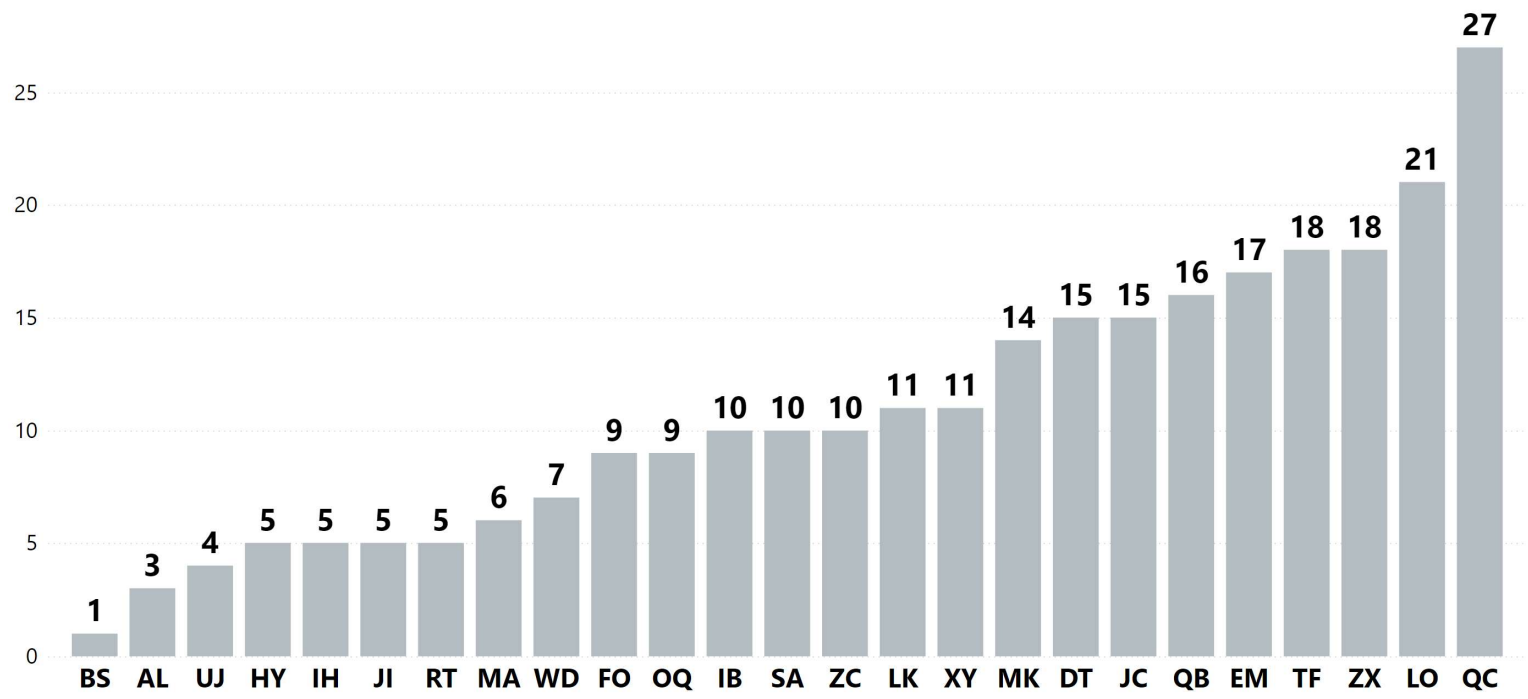
LUNG WORKING GROUP

ENROLLMENT FOR LUNG PROJECT

Data as of 5/1/2026

ENROLLMENT BY FACILITY



Facilities with no data

AI

WP

ENROLLMENT FOR LUNG PROJECT

Data as of 5/1/2026

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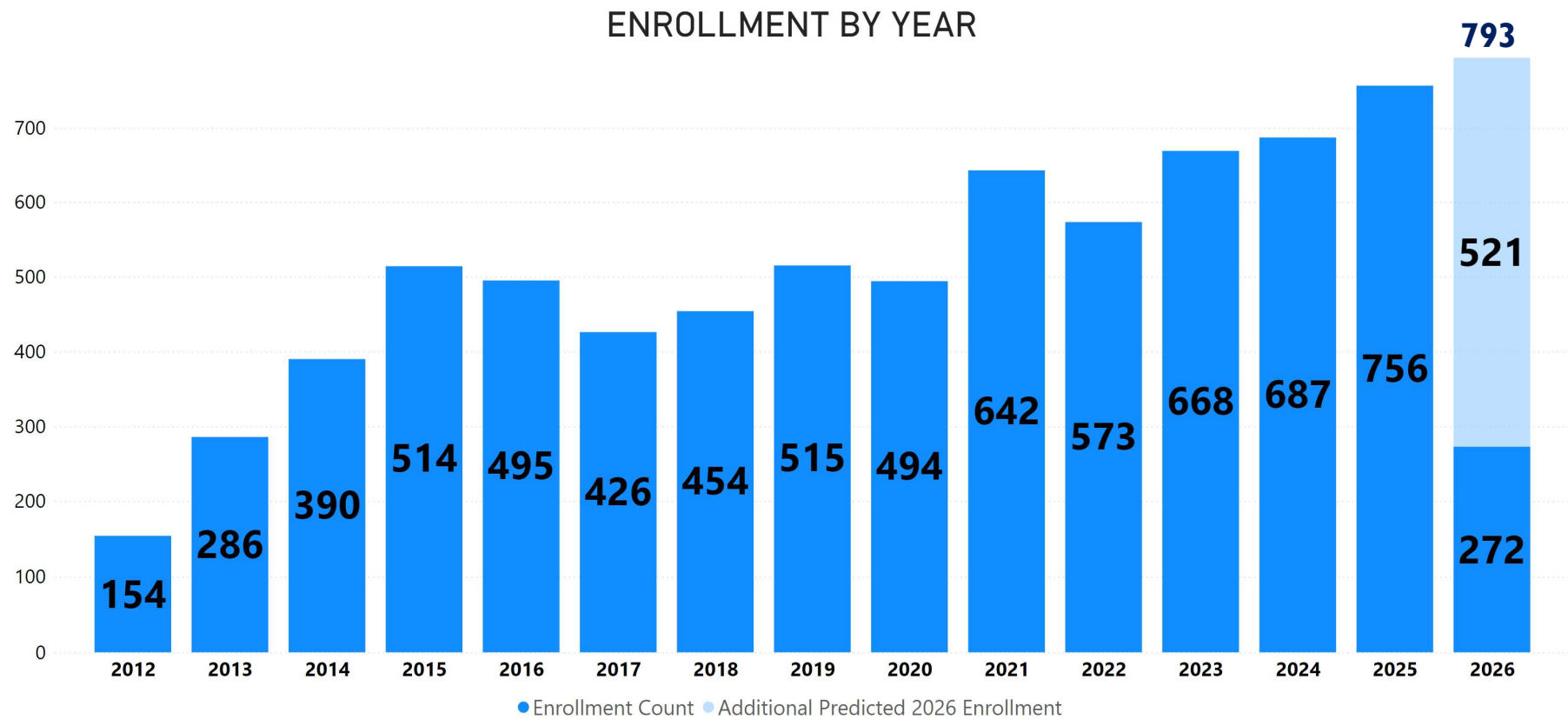
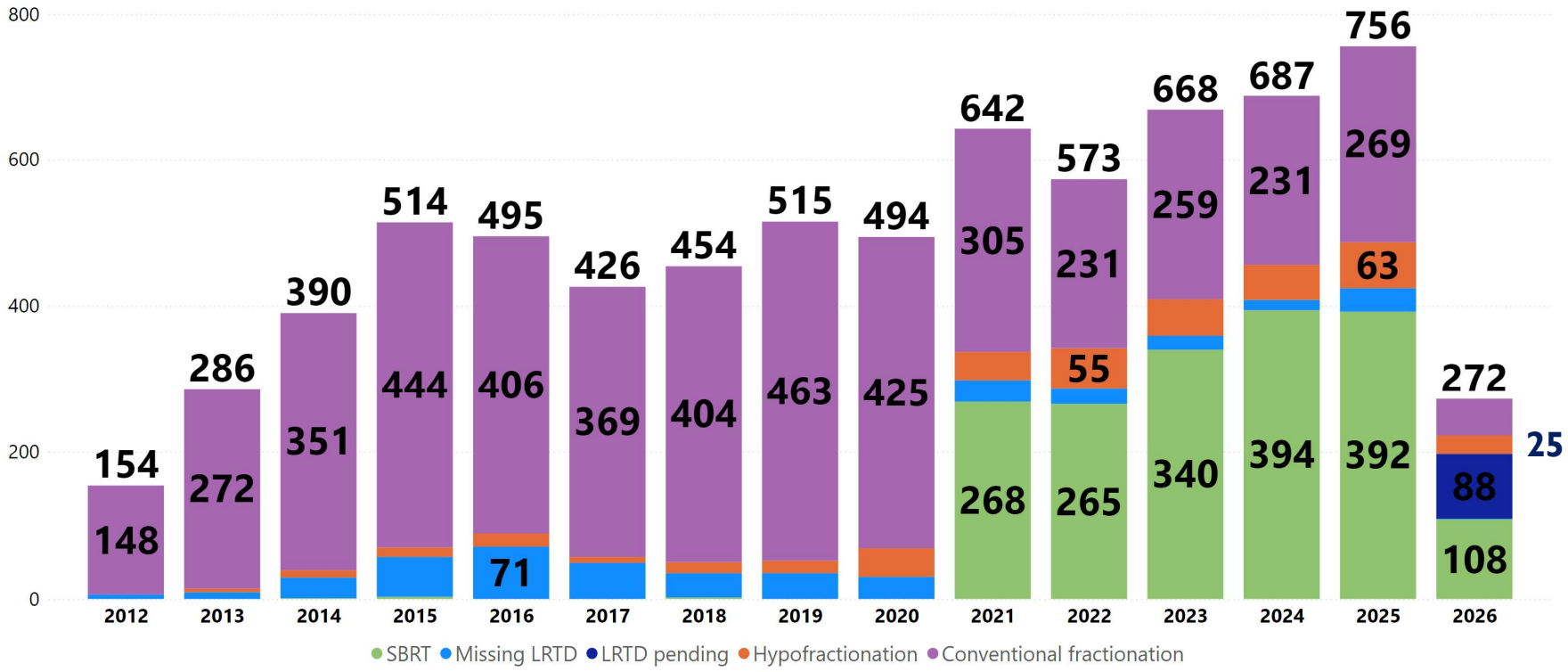
LUNG WORKING GROUP



ENROLLMENT FOR LUNG PROJECT

Data as of 5/1/2026



Lung Working Group Status Update: Quality Measure Performance

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2026 Lung Collaborative-Wide Measure

For treatment of lung cancer with hypofractionation (6-20 fractions), MROQC Consensus Quality Guidelines are achieved for at least 75% of patients collaborative-wide.

10 Points	≥75% of patients treated with hypofractionation (6-20 fx) for lung cancer across MROQC achieved the phase I guideline fractionation & dosimetric goals
5 Points	60-74% of patients treated with hypofractionation (6-20 fx) for lung cancer across MROQC achieved the phase I guideline fractionation & dosimetric goals
0 Points	<60% of patients treated with hypofractionation (6-20 fx) for lung cancer across MROQC achieved the phase I guideline fractionation & dosimetric goals

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This measure is part of 2026 P4P and 2027 CQIVBR

MROQC Lung Hypofractionation Guideline Adherence

Lung Hypofractionation Guidelines Measure

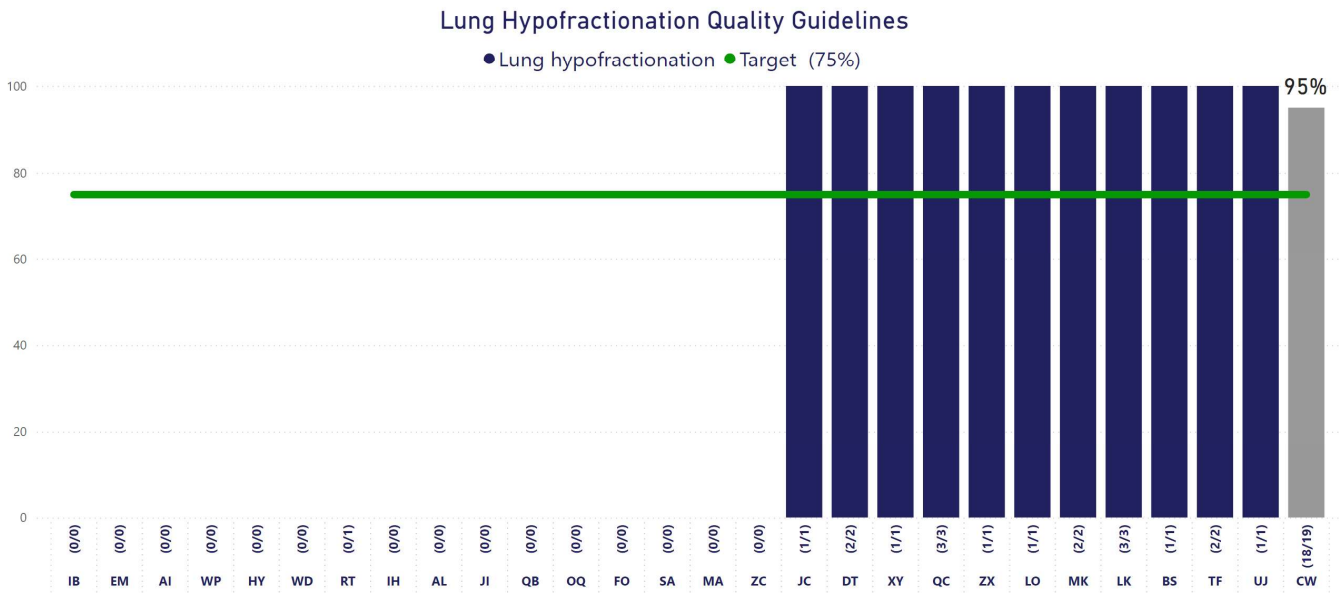
The 2026 Performance Period includes cases who started RT 01/01/2026-09/30/2026

Data Refreshed as of 05/01/2026

Measure Description:

For treatment of lung cancer with hypofractionation (6-20 fractions), MROQC Consensus Quality Guidelines are achieved.

Full points: >=75% of patients treated with hypofractionation (6-20 fx) for lung cancer across MROQC achieved the phase 1 guideline fractionation & dosimetric goals
Partial Points: 60-74% of patients treated with hypofractionation (6-20 fx) for lung cancer across MROQC achieved the phase 1 guideline fractionation & dosimetric goals
Zero Points: <60% of patients treated with hypofractionation (6-20 fx) for lung cancer across MROQC achieved the phase 1 guideline fractionation & dosimetric goals



Hypofx Quality Measure Roadmap

Phase 1

Follow High Priority/High Consensus Goals for Fractionation and Dosimetric Limits Consortium Wide

- **8, 10, or 15-20 Fx**
- PTV
- Esophagus
- Bronchus/Trachea
- Cord

Phase 2

Follow Consensus Goals for Fractionation, Tradeoffs, and Dosimetric Limits at a facility level or consortium wide, depending on Phase I

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LUNG WORKING GROUP

MROQC Lung Hypofractionation Guidelines (2026)

Goal

Standardize lung hypofractionation practices across MROQC facilities

Appropriate Use

- Stage I–II patients not ideal for SBRT
- Select Stage III patients not eligible for chemotherapy

Phase 1 Recommendation

Use 8, 10, or 15 fractions for hypofractionation as an SBRT alternative

Planning Priorities

1. Meet critical OAR constraints
2. Maintain PTV coverage/conformity
3. Minimize secondary OAR dose

Key Dosimetric Themes

- PTV D95% = 100%
- Prioritize spinal cord, esophagus, brachial plexus, heart, and airway constraints
- Lung dose kept **ALARA**

Foundation

Built from:

- Existing MROQC practice patterns
- Lung WG consensus
- NRG Oncology guidance

Consensus recommendations will evolve with future evidence and MROQC experience.

Questions regarding the current lung measure?

Expanded Toxicity Collection

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Data Collection Addition for Hypofractionated Lung Treatments

Background

- A request has been made to consider adding toxicities related to hypofractionated lung treatments
- NRG does not have a robust dataset in this space

Outcome of Interest

- Rib/chest wall pain identified as a potentially important outcome
- Particularly relevant for SBRT and other hypofractionated treatments

Rationale

- Rib/chest wall toxicity is a known risk with high-dose per fraction regimens
- Additional data may help better understand treatment-related toxicity patterns

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We are proposing two new questions:

Did the patient develop chest wall pain attributable to radiation?

Chest Wall Pain (CTCAE graded)

- None
- Grade 1 – mild
- Grade 2 – moderate (limits instrumental ADLs)
- Grade 3+ – severe

Did the patient develop a rib fracture within the radiation field?

- No
- Yes – asymptomatic
- Yes – symptomatic

Join Us!

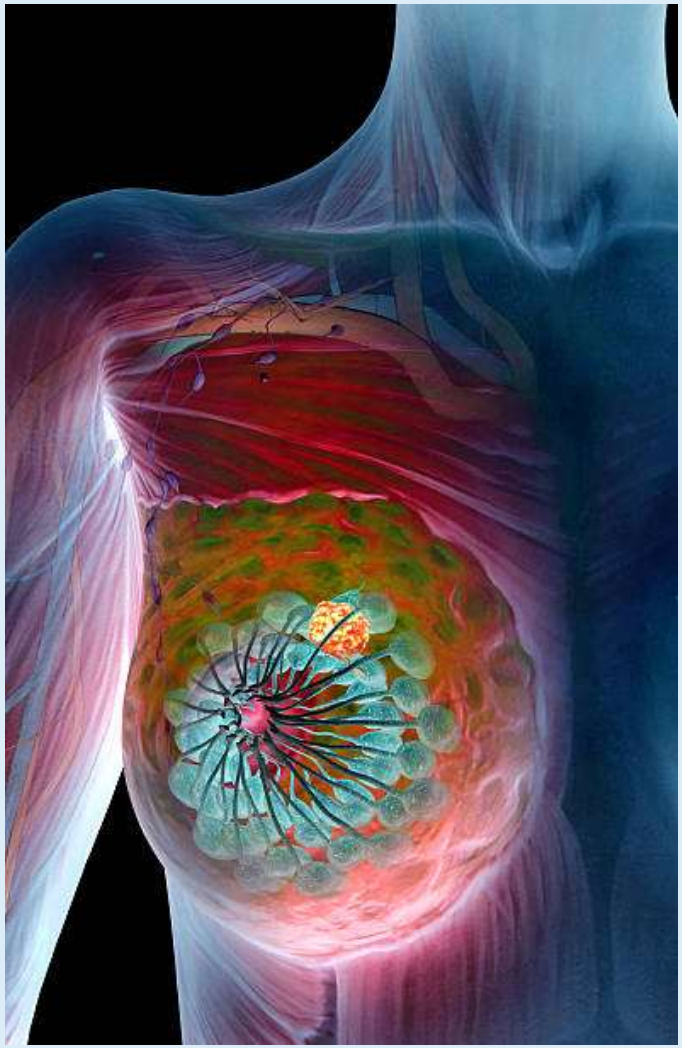
Our Next Lung Working Group Meeting:

Monday, June 15th from 12:00-1:00p.m.

MROQC Quality Improvement Breast Working Group Update

May 15, 2026

Lori Pierce, Frank Vicini, Alex Moncion



MR QC
BREAST WORKING GROUP

Today's Agenda

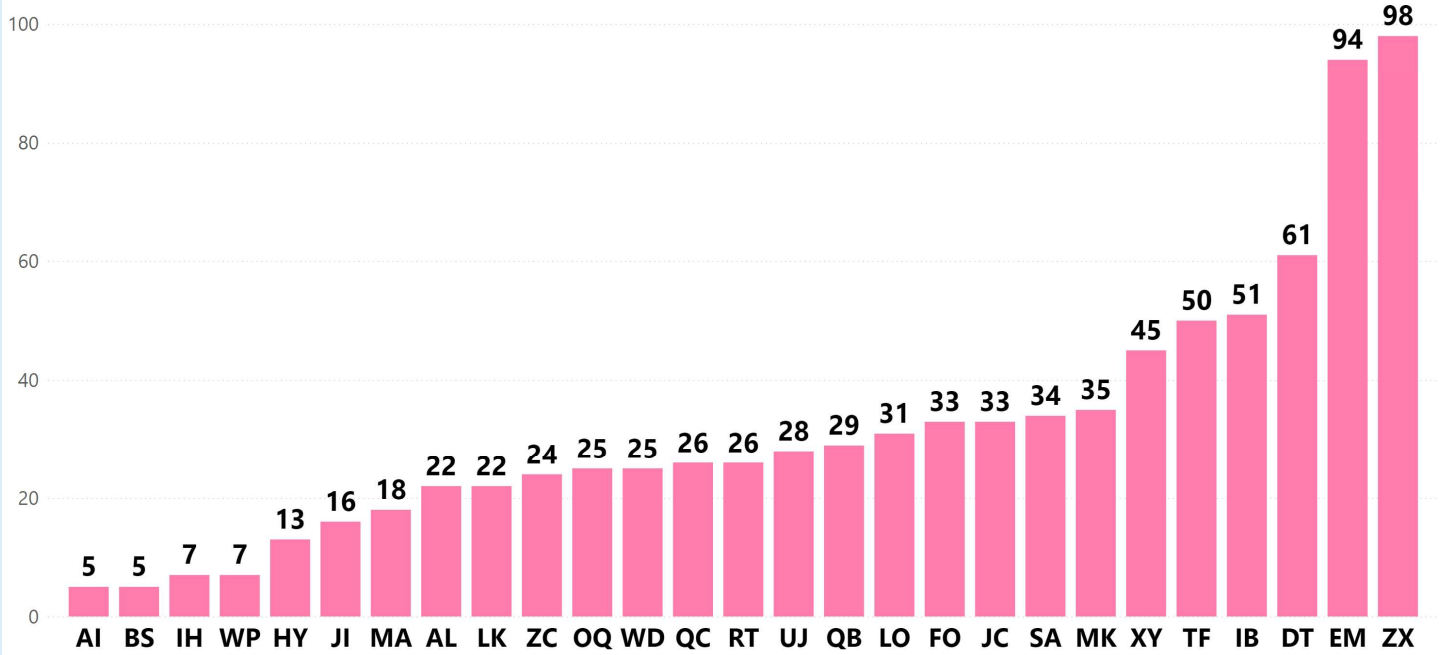
WORKING GROUP STATUS UPDATES

FUTURE PROJECT UPDATES

ENROLLMENT FOR BREAST PROJECT

Data as of 5/1/2026

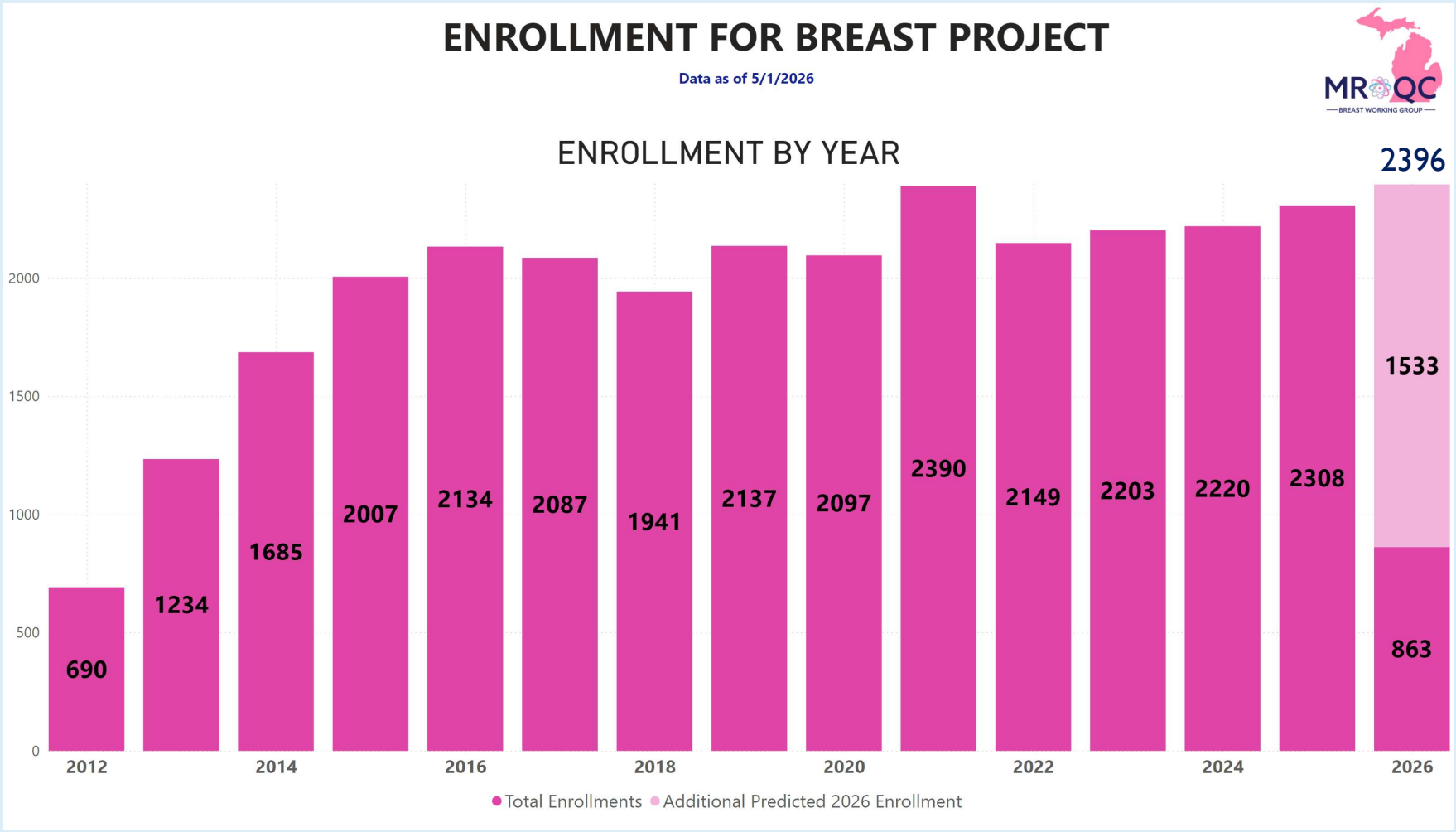
ENROLLMENT BY FACILITY

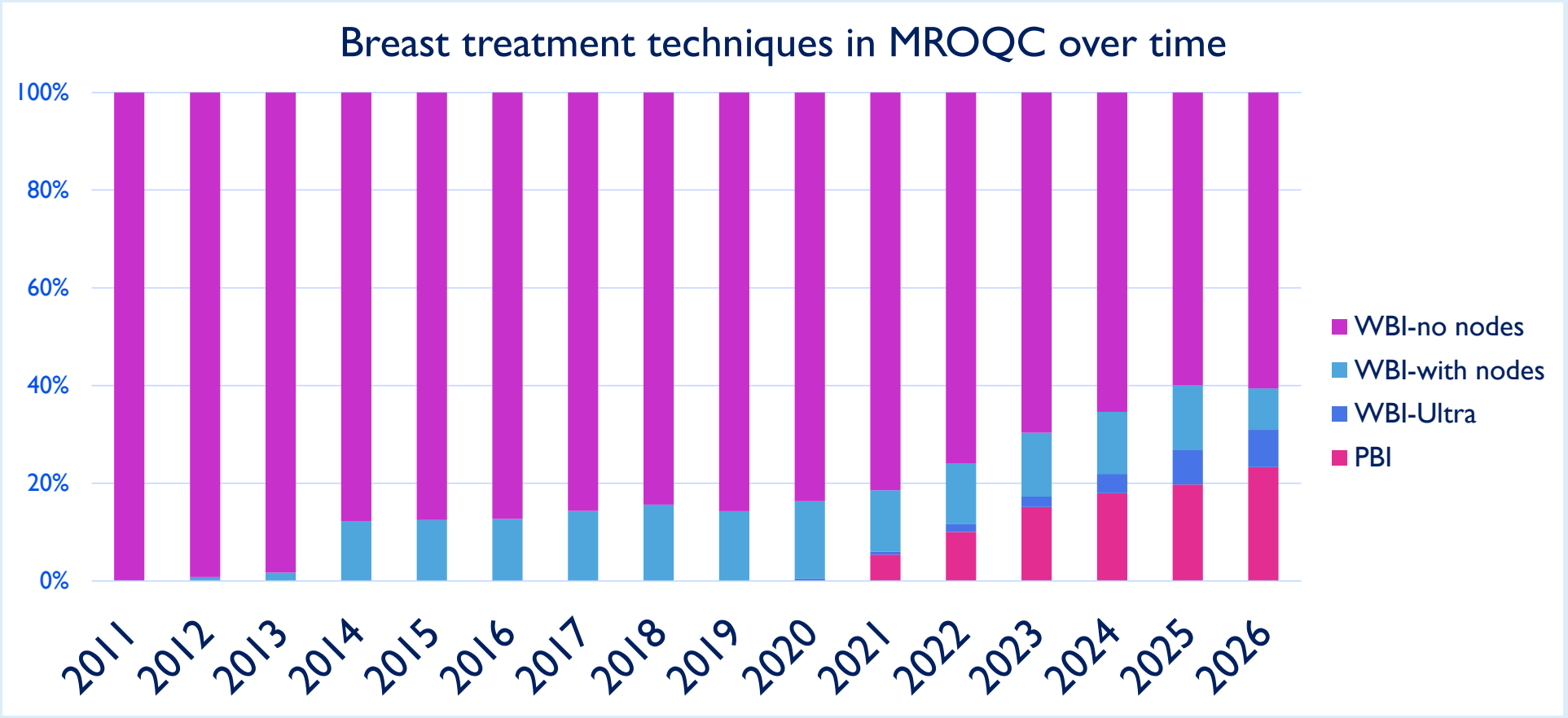


Facilities with no data

ENROLLMENT FOR BREAST PROJECT

Data as of 5/1/2026





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Breast Quality Improvement Initiatives

Prone positioning

Completion of arm measurements for lymphedema assessment

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2026 MROQC Collaborative-Wide Goal

Increase the collaborative-wide utilization of prone positioning for breast cancer radiation treatment

10 Points	≥40% of breast cancer patients were treated in the prone position across MROQC
5 Points	30-39% of breast cancer patients were treated in the prone position across MROQC
0 Points	<30% of breast cancer patients were treated in the prone position across MROQC

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This measure is part of 2026 P4P and 2027 CQI VBR

Motivation for the Prone Positioning Measure

Population:

- Left-sided, hypofractionated (2.5-2.7 Gy/fx) whole breast (boost not included in analysis if present) treated between 2018-2022.

Metrics:

- Tumor bed PTV: D95%[%]≥95
- Heart: Mean[Gy]≤1

To be eligible:

- Must have TG263 compliant heart and PTV surgical bed structures
- Multiple whole breast plans are excluded

Resulting Sample Size:

- N=2,492
  - Supine Without Motion Management (w/o MM): 726
  - Supine With Motion Management (w/ MM): 1,178
  - Prone: 588

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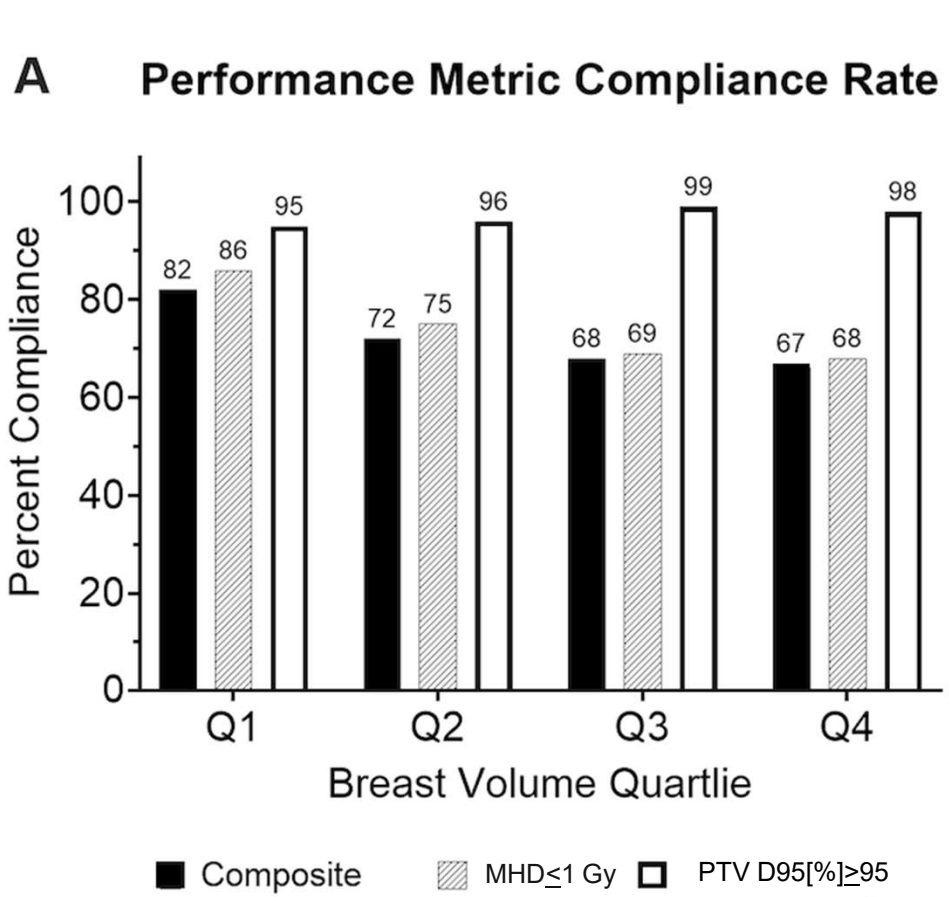
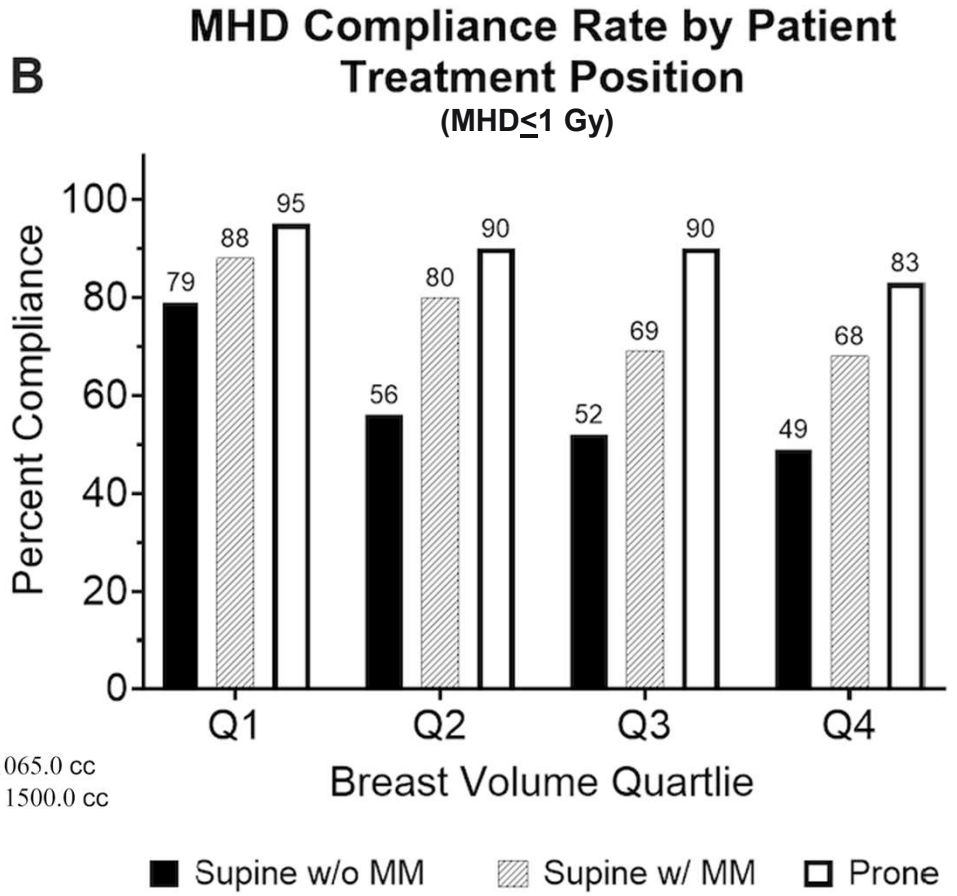
Motivation for the Prone Positioning Measure



Q1: ≤ 720.0 cc
Q2: 720.1 to ≤ 1065.0 cc
Q3: 1065.1 to ≤ 1500.0 cc
Q4: 1500.1+ cc



Prone Positioning Quality Measure for Breast

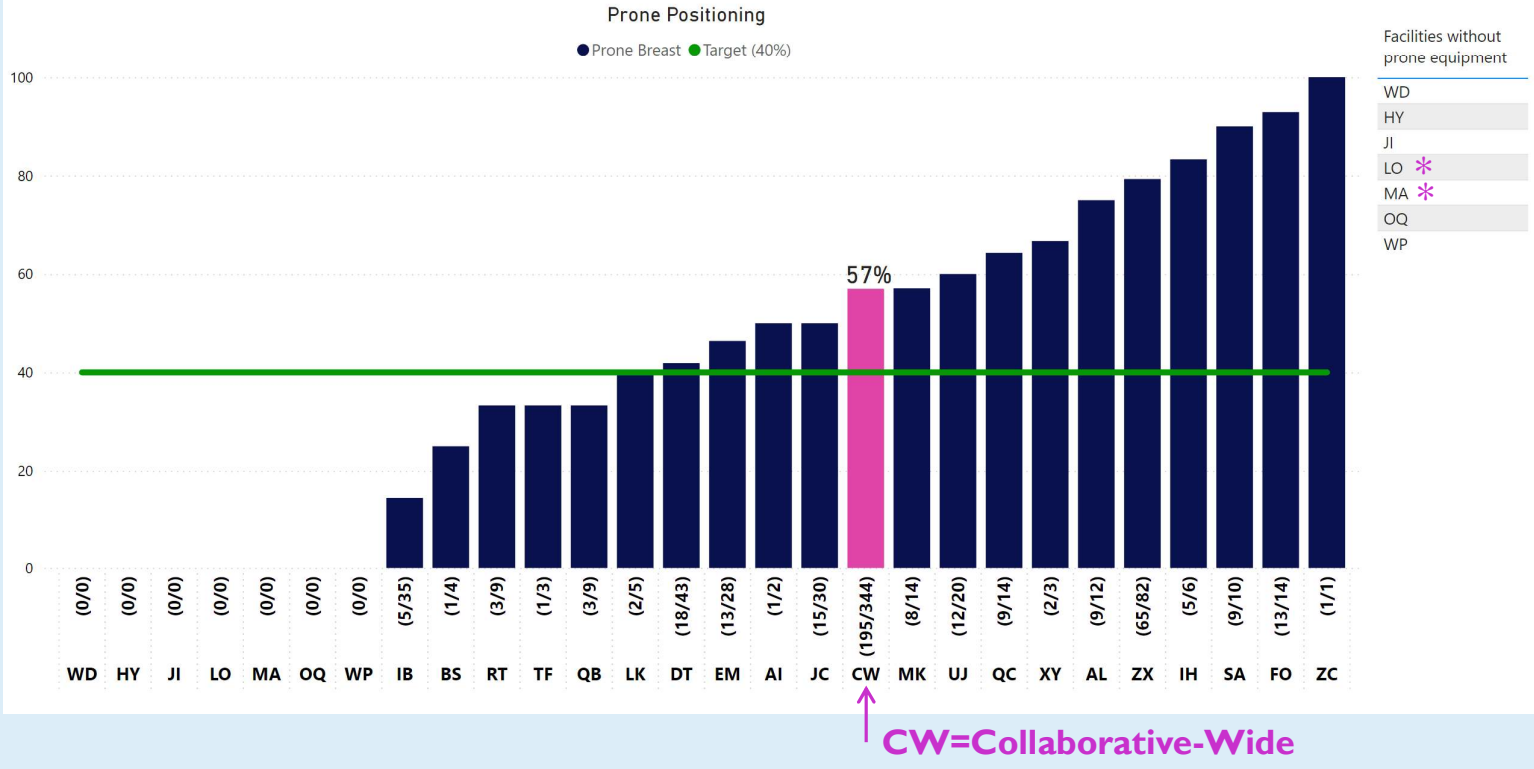
The 2026 Performance Period includes cases who started RT 01/01/2026-09/30/2026

Data Refreshed as of 05/08/2026

Measure Description:

Increase the collaborative-wide utilization of prone positioning for breast cancer radiation treatment

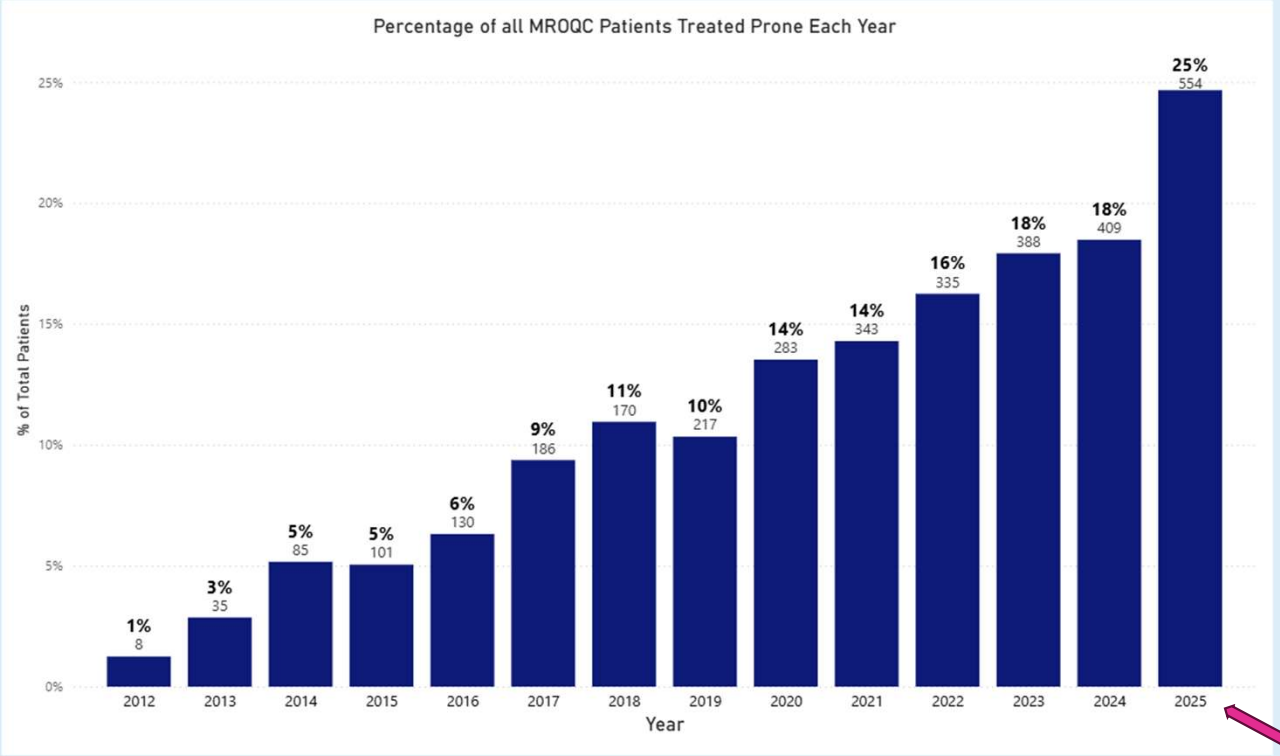
Full Points: ≥40% of breast patients were treated in the prone position across MROQC
Partial Points: 30-39% of breast patients were treated in the prone position across MROQC
Zero Points: <30% of breast patients were treated in the prone position across MROQC



CW=Collaborative-Wide

* Have boards; currently no prone patients treated in 2026

Driving Change in Practice: Prone Positioning Adoption Trends



Launch of collaborative-wide prone breast quality measure

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Lymphedema Measurements for Patients Receiving Regional RT

Increase the baseline and post-radiation treatment (RT) completion rate of standard of care arm measurements for lymphedema assessment in node positive breast cancer patients treated to regional fields.

A. >= 50% of breast patients treated to regional fields with a baseline measurement (B7 or B9) in 2025 must have a follow-up measurement (B10 or B14) completed and reported in cm within Q1-Q3 of 2026.

B. >= 50% of breast patients treated to regional fields with a RT start date within Q1-Q3 of 2026 must have a baseline measurement (B7 or B9) reported in cm and complete nodal irradiation data (dose to irradiated nodal groups is reported and nodal contours are named according to TG263 guidelines).

10 Points	A and B were met
7 Points	Either A or B were met
0 Points	Neither A nor B were met

MR QC
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This measure is part of 2026 P4P|2027 Gold Card|2027 CQI VBR

Lymphedema Assessment Quality Measure for Breast: Part A

The 2026 Performance Period includes cases who started RT 01/01/2026-09/30/2026

Data Refreshed as of 05/01/2026

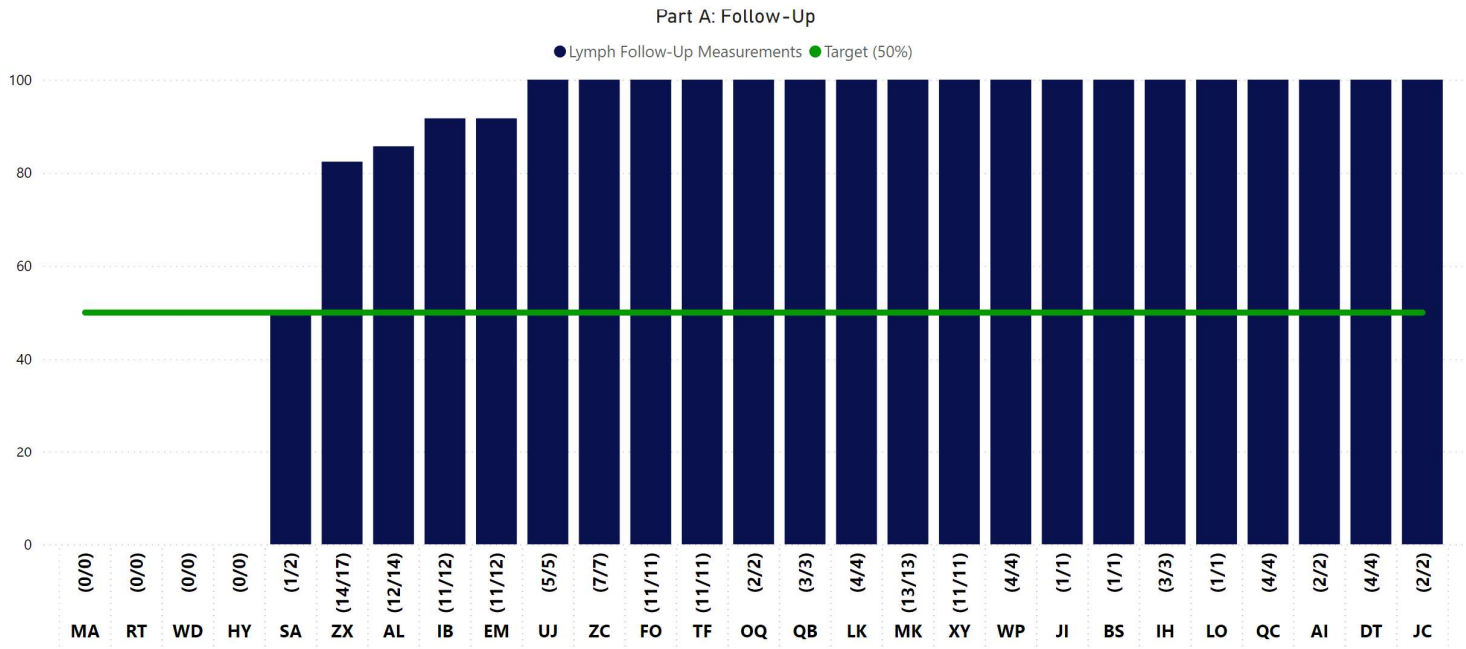
Measure Description:

Increase the baseline and post-radiation treatment (RT) completion rate of standard of care arm measurements for lymphedema assessment in node positive breast cancer patients treated to regional fields.

A. ≥50% of breast patients treated to regional fields with a baseline measurement (B7 or B9) in 2025 must have a follow-up measurement (B10 or B14) completed within Q1-Q3 of 2026.

B. ≥50% of breast patients treated to regional fields with a RT start date within Q1-Q3 of 2026 must have a baseline measurement (B7 or B9) reported in cm and complete nodal irradiation data (dose to irradiated nodal groups is reported and nodal contours are named according to TG263 guidelines).

Full Points: A and B were met. Partial Points: Either A or B was met. Zero Points: Neither A or B was met.



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Lymphedema Assessment Quality Measure for Breast: Part B

The 2026 Performance Period includes cases who started RT 01/01/2026-09/30/2026

Data Refreshed as of 05/01/2026

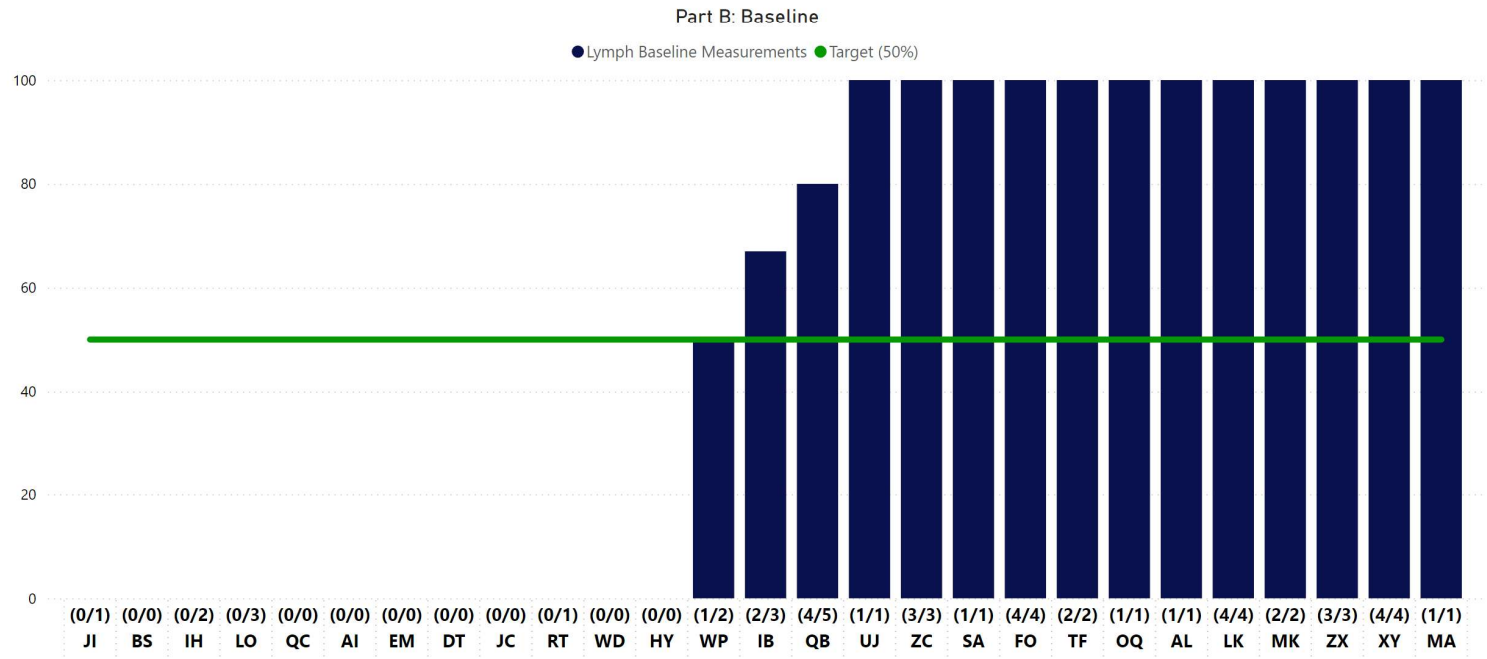
Measure Description:

Increase the baseline and post-radiation treatment (RT) completion rate of standard of care arm measurements for lymphedema assessment in node positive breast cancer patients treated to regional fields.

A. ≥50% of breast patients treated to regional fields with a baseline measurement (B7 or B9) in 2025 must have a follow-up measurement (B10 or B14) completed within Q1-Q3 of 2026.

B. ≥50% of breast patients treated to regional fields with a RT start date within Q1-Q3 of 2026 must have a baseline measurement (B7 or B9) reported in cm and complete nodal irradiation data (dose to irradiated nodal groups is reported and nodal contours are named according to TG263 guidelines).

Full Points: A and B were met. Partial Points: Either A or B was met. Zero Points: Neither A or B was met.



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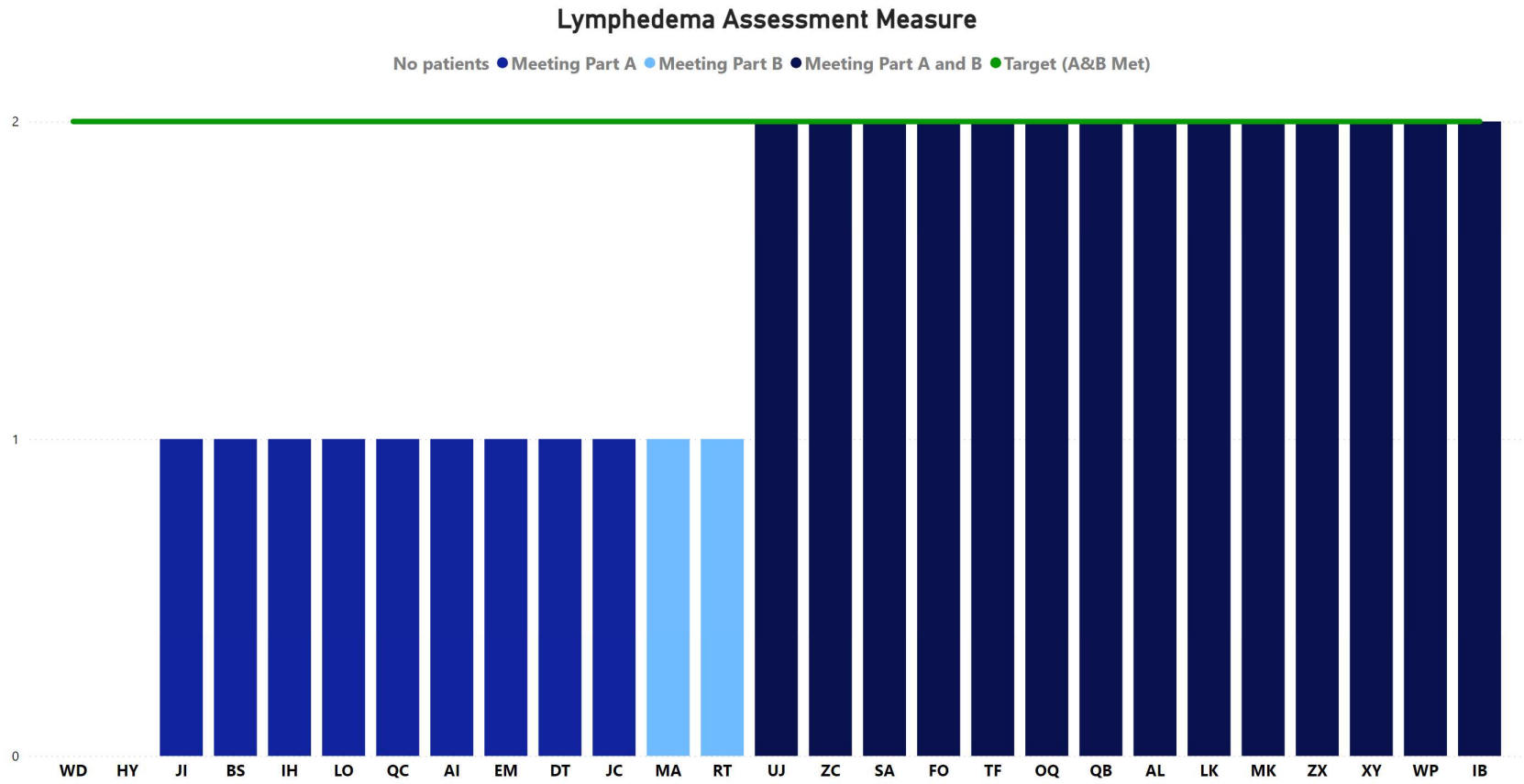
Lymphedema Assessment Quality Measure for Breast: Part A & B Combined

The 2026 Performance Period includes cases who started RT 01/01/2026-09/30/2026

Data Refreshed as of 05/08/2026



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Any thoughts from the group?

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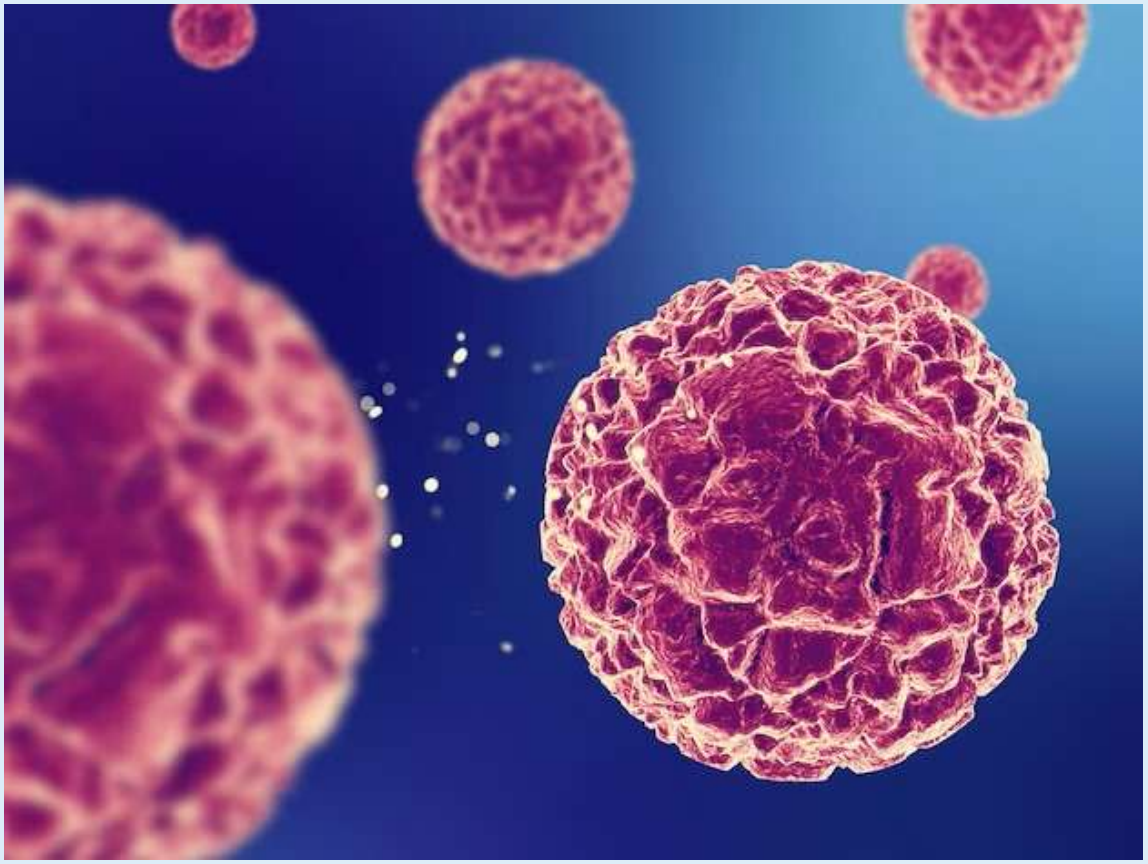
PMRT



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Post-Mastectomy Radiation Therapy (PMRT)

ARTICLE IN PRESS

Practical Radiation Oncology® (2025) 000, 1–23

pro

www.practicalradonc.org

Clinical Practice Guideline

Postmastectomy Radiation Therapy: An ASTRO/ASCO/SSO Clinical Practice Guideline

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Sources of support: This work was funded by the American Society for Radiation Oncology.

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*Corresponding author: Rachel Jimenez, MD; Email: rbjimenez@mgh.org

https://doi.org/10.1016/j.pro.2025.05.001

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A Post-Mastectomy Radiation Therapy (PMRT) Committee was formed in early 2026.

Thank you to Mike Dominello, Mazen Mislmani, Mark Zaki, Shelley Tibbs, Terri Bott-Kothari, Lori, Frank, and Robin for volunteering.

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PMRT Volume & Reconstruction Snapshot

20 MROQC Facilities Responded

Total PMRT Patients: 534
Average per Facility: ~30

Volume Distribution:
Low (<20): 9 facilities
Mid (20–50): 9 facilities
High (>50): 2 facilities

Reconstruction:
With: 276 (52%)
Without: 258 (48%)

Reconstruction Type:
Implant-based: ~90%
Autologous: ~10%

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Draft List of Things to Collect

- Reconstruction
- Toxicities
- Systemic Agents
- Practice Patterns
- Use of Bolus
- Cosmesis
- Timing of RT & Implant Exchange

Are there any additional data elements or areas of interest that you feel would be valuable for us to collect?

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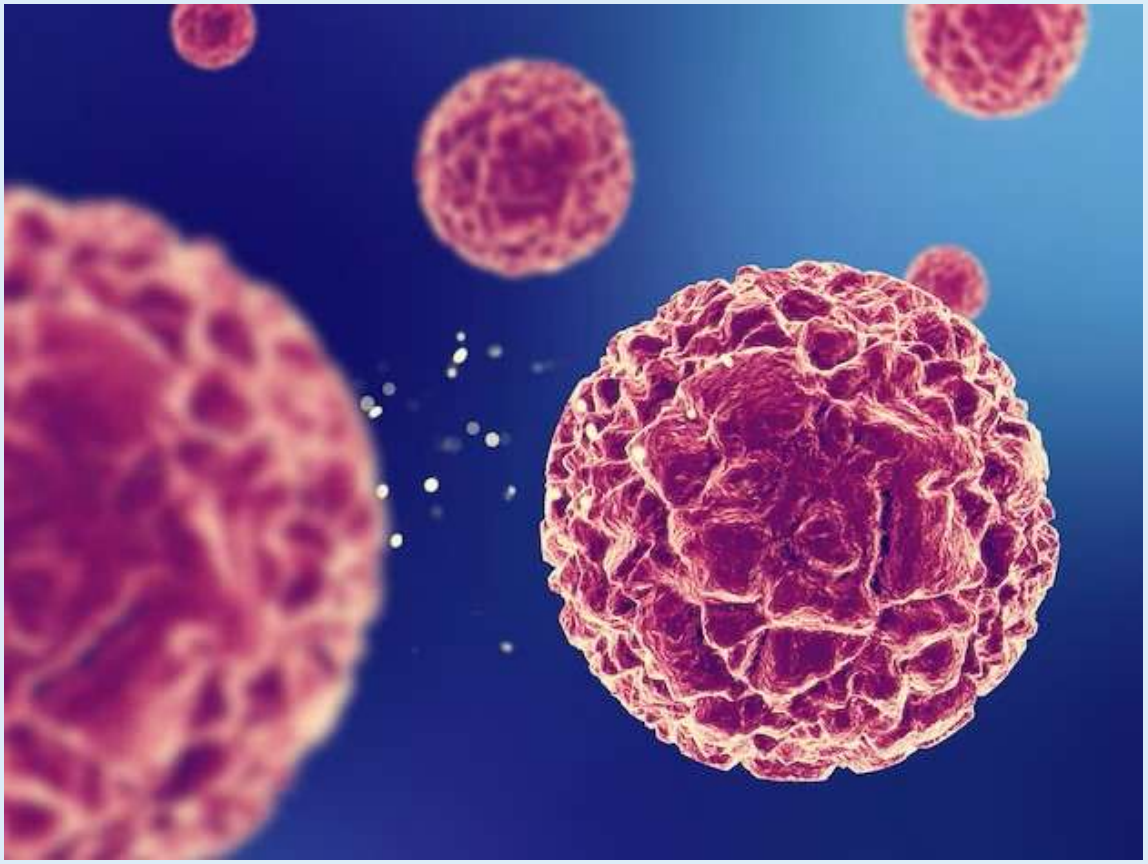
Long Term Follow Up



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MROQC Breast Long Term Follow Up (10-Yr) Draft Form

MROQC BREAST WORKING GROUP

Breast Long Term Follow-up Form

Patient ID: _____

Review Date_____

To be completed by the CDA at 10 years after completion of radiation treatment. If no information is available to complete this form, report this on the SE2 form and close the patient record.

1. **Survival Status at the time of follow-up (select one):** If the patient is deceased, report the date of death, complete the SE2 form, and proceed to question 5.
   - ☐1 Alive with no evidence of disease
   - ☐2 Alive with disease
   - ☐3 Deceased with no evidence of disease
   - ☐4 Deceased with disease

2. **Disease Recurrence**:
   Complete this section only if the patient is alive or has and has had a recurrence at the time of follow-up.

   First recurrence: Site of first recurrence (check all that apply):
   - ☐1 Local (breast)
   - ☐2 Regional nodes (axilla, supraclavicular, IMN)
   - ☐3 Distant (specify site): _____

   Date of first recurrence4 (mm/yyyy): _____
   Date unknown 5☐

   Management of first recurrence (check all that apply):
   - ☐6 Local excision
   - ☐7 Mastectomy
   - ☐8 Radiation therapy
   - ☐9 Endocrine therapy
   - ☐10 Chemotherapy
   - ☐11Other (specify): _____

   Any subsequent recurrence12: Site and date (mm/yyyy):
   _____
   Date unknown 13☐

3. **Has the patient had any new cancer diagnoses since completing treatment?**
   - ☐1 Yes – if yes, report type, site, and date of diagnosis
   - ☐2 No – if no, proceed to Cardiac History

   If Yes:
   - ☐3 **Breast cancer**

   Date of diagnosis4 (mm/yyyy): _____
   Date unknown 5☐
   - ☐6 **Other cancer Type**: _____

   Site & laterality7: _____
   Date of diagnosis 8(mm/yyyy): _____
   Date unknown 9☐

4. **Cardiac History**
   a. **Cardiovascular risk factors (check all that apply):**
      - ☐1 Diabetes
      - ☐2 History of Adriamycin Use
      - ☐3 History of Herceptin Use
      - ☐4 Hyperlipidemia
      - ☐5 Hypertension
      - ☐6 Smoking History
      - ☐7 Stroke

   b. **Since the end of treatment, has the patient been diagnosed with a cardiac risk factor or event?**
      - ☐1 Yes
      - ☐2 No - If No, all required questions have been completed.

   c. **If Yes: Select the cardiac event(s) and report date of diagnosis (mm/yyyy):**
      - ☐3 Angina
        Date: _____ ☐ Unknown
      - ☐4 Arrhythmia
        Date: _____ ☐ Unknown
      - ☐5 Cerebrovascular Event (Stroke)
        Date: _____ ☐ Unknown
      - ☐6 Congestive Heart Failure
        Date: _____ ☐ Unknown
      - ☐7 Myocardial Infarction
        Date: _____ ☐ Unknown
      - ☐8 Pericardial Effusion
        Date: _____ ☐ Unknown
      - ☐9 Valvular Heart Disease
        Date: _____ ☐ Unknown
      - ☐10 Other (Specify):_____
        Date: _____ ☐ Unknown

MROQC BREAST WORKING GROUP

Thank You to Our Long Term Follow Up Pilot Facilities

- Michigan Medicine
- Henry Ford Providence
- Munson
- West Michigan Cancer Center

Interested in being a pilot facility? Please reach out to support@mroqc.org

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BREAST WORKING GROUP

Join Us!

Our Next Working Group Meeting will be:

Thursday, June 25th

12:00-1:00 p.m.

MROQC Prostate Quality Improvement Working Group Update

May 15, 2026

Bob Dess, Dave Heimburger, Karolyn Hopfensperger

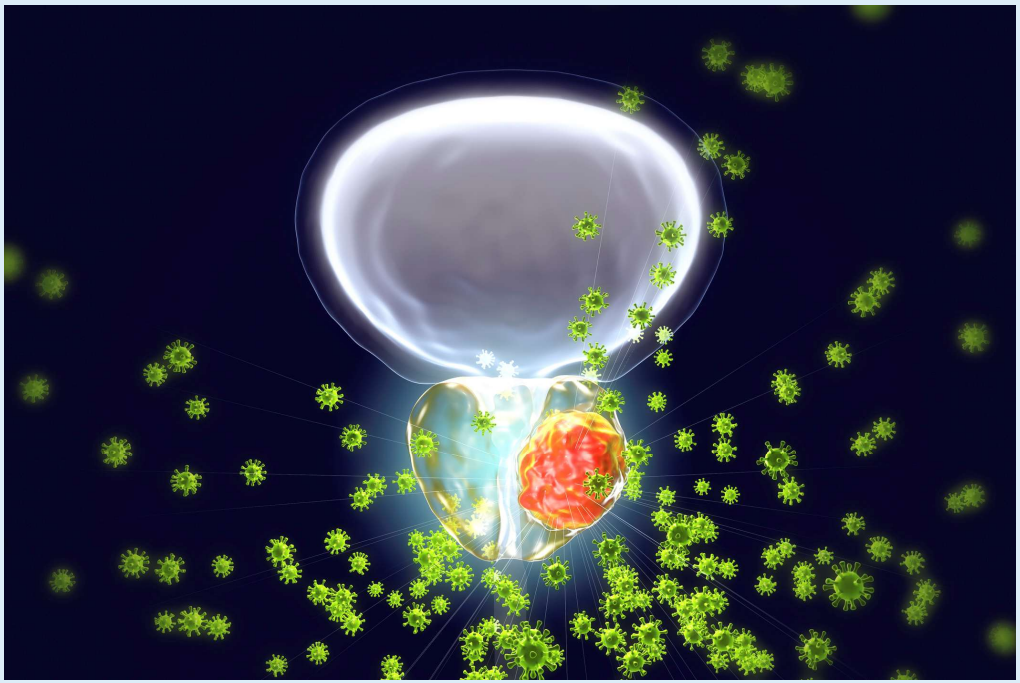
MR QC
— PROSTATE WORKING GROUP —

Today's Agenda

WORKING GROUP STATUS UPDATE

HOT TOPICS:
NEW QUALITY MEASURE(S)

Prostate Working Group Status Update

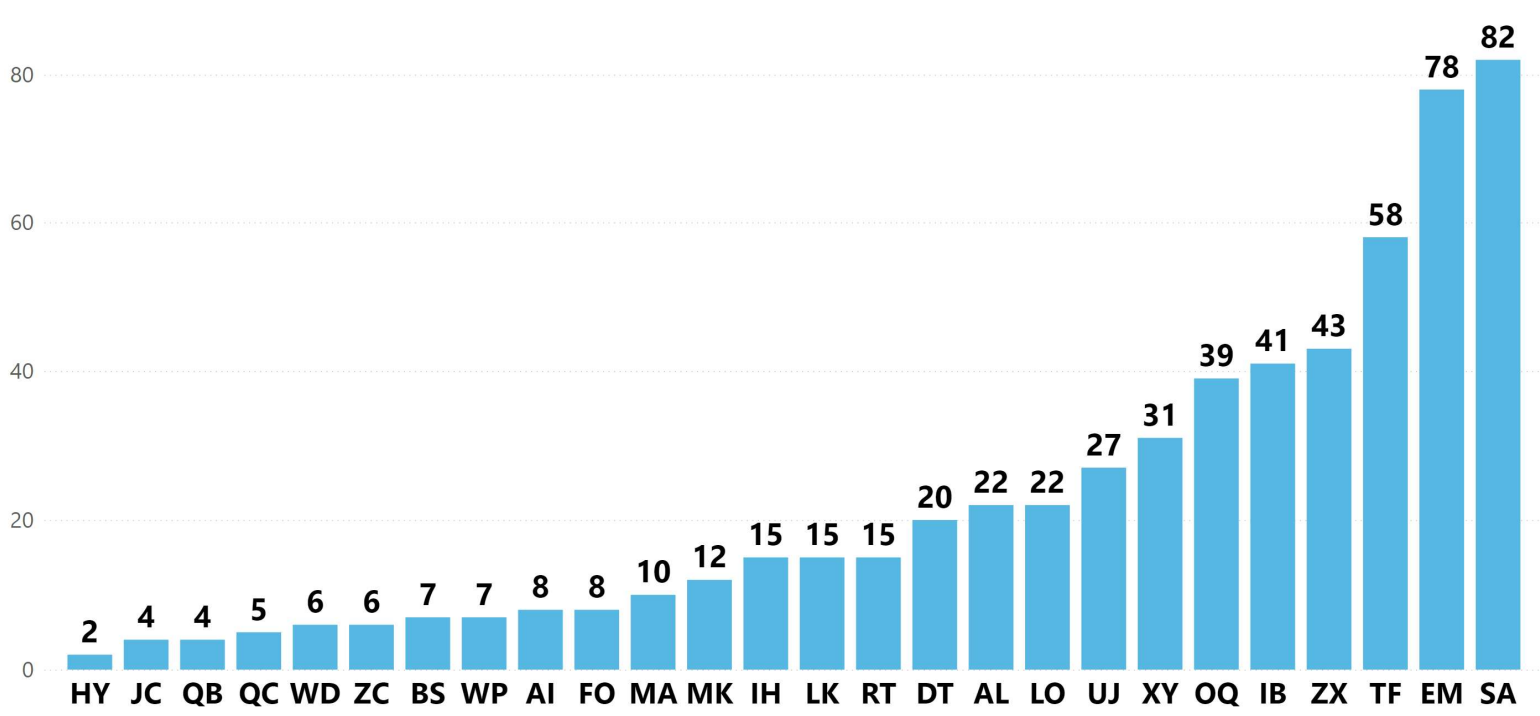


MR QC
— PROSTATE WORKING GROUP —

ENROLLMENT FOR PROSTATE PROJECT

Data as of 5/1/2026

ENROLLMENT BY FACILITY

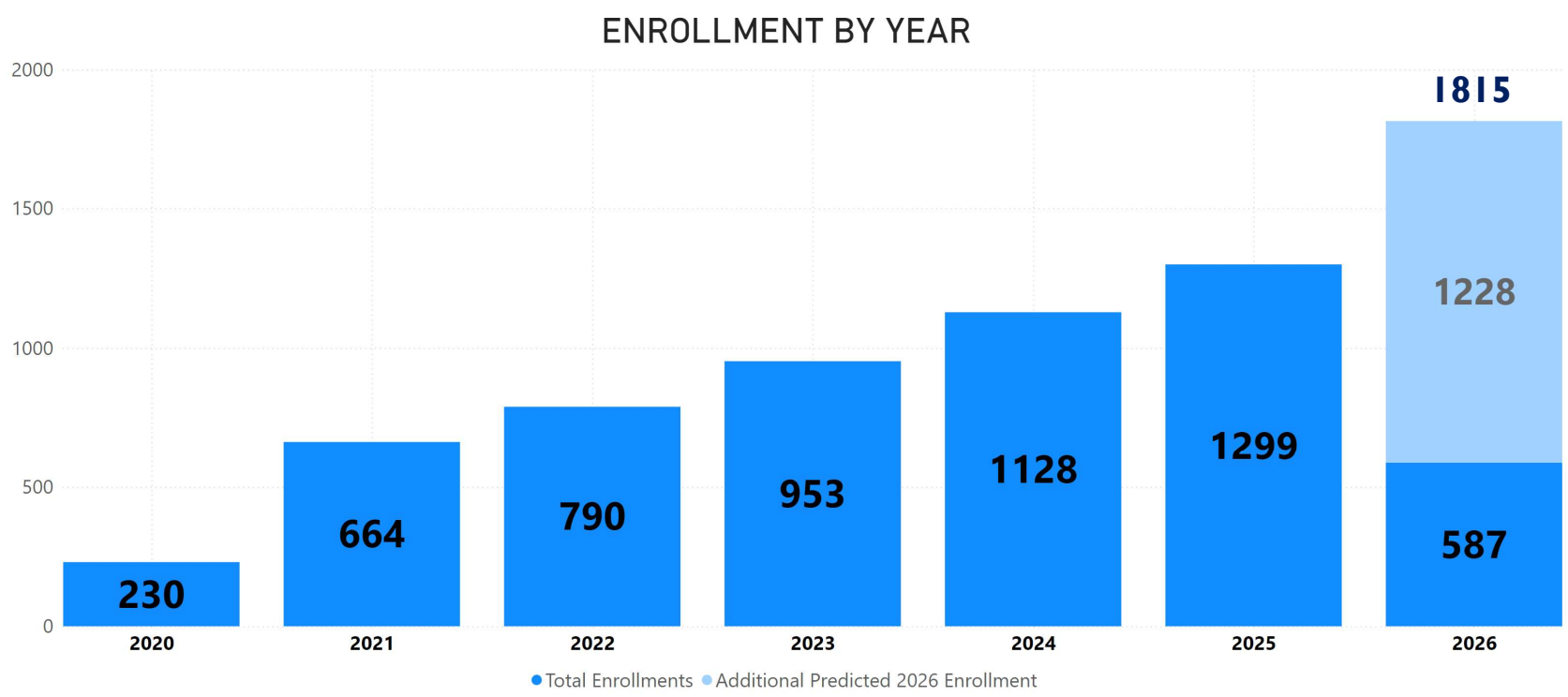


Facilities with no data

JI

ENROLLMENT FOR PROSTATE PROJECT

Data as of 5/1/2026

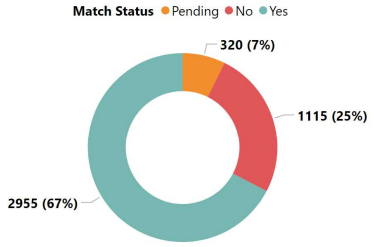


PROSTATE MATCHING DASHBOARD

Data current as of 05/11/2026

Matching Rate - Consortium Wide

Includes only Matching Facilities



Pending status includes patients <26 weeks from enrollment without a match from MUSIC

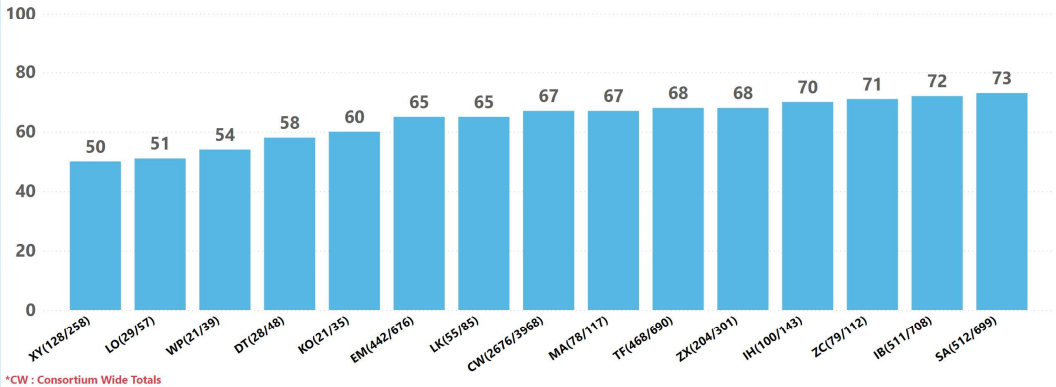
Enrollment / Matching Breakdown	Current	Last Report 4/20/2026
Enrolled Patients (All Facilities)	9901	9732
Enrolled Patients (Matching Facilities)	7340	7232
Eligible Patients (All Facilities)	5811	5681
Eligible Patients (Matching Facilities)	4390	4299
Matched Patients (From Matching Facilities)	2955	2918

*Facility 5172: exclude cases enrolled before 4/25/22
*Facility 5173: exclude cases enrolled after 8/23/22
*Facilities 154, 155, 158, 23932,23933,31028: exclude cases enrolled after 1/30/23
*Facility 976 exclude cases enrolled between 1/30/2023 and 8/14/2023

Matching Rate by Site

For Current Matching Sites

Intact and Post op patients | Matching Rate by Facility

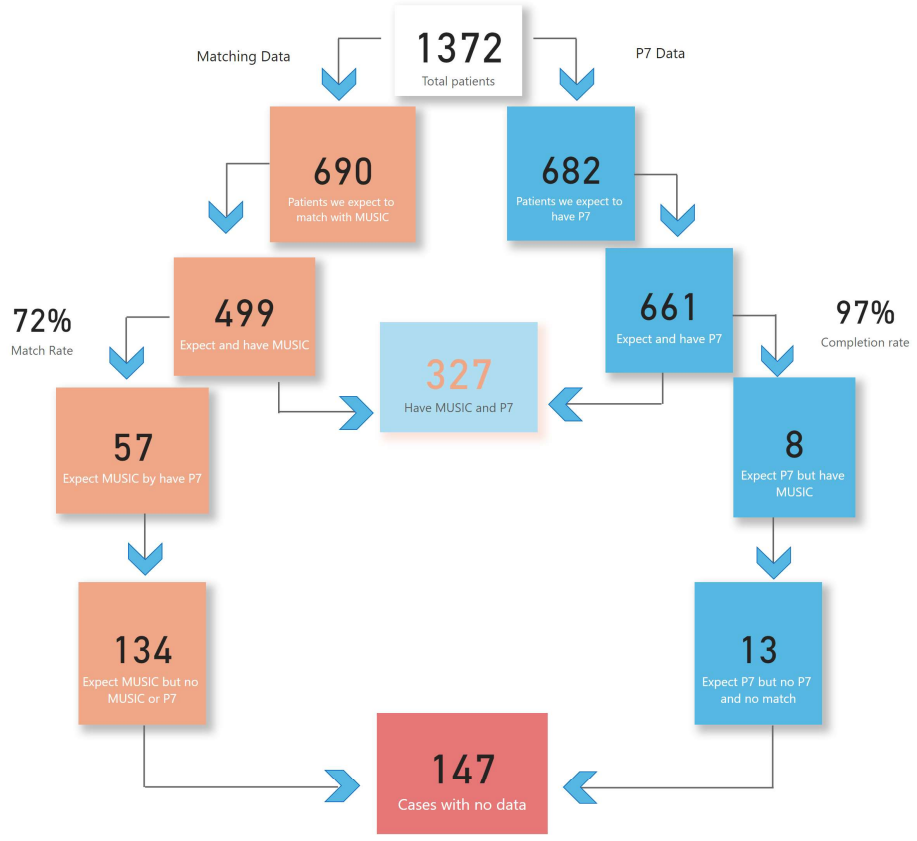


*CW : Consortium Wide Totals

MATCHING AND P7 RATES

Treatment start dates from 1/1/2025-Present

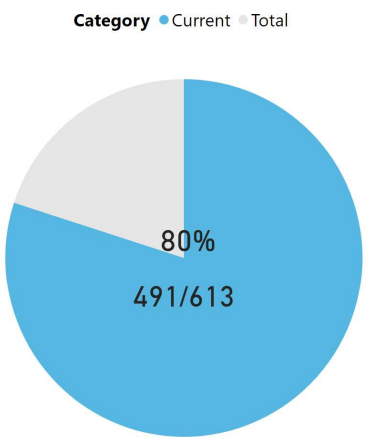
Data current as of **5/11/2026**



BASELINE FORM DATA DASHBOARD

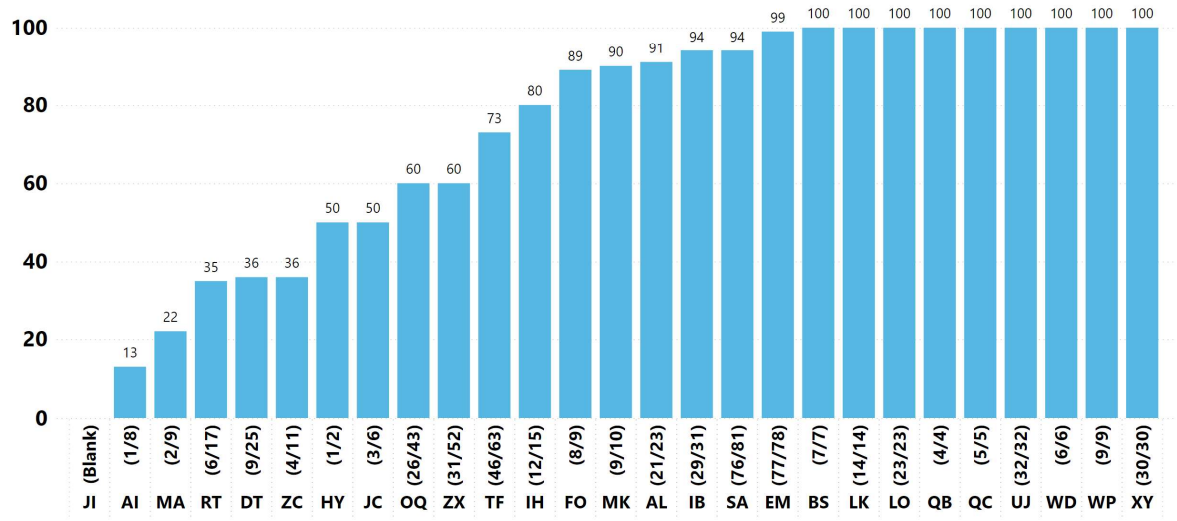
Data current as of 05/11/2026

Baseline Form Completion Rate Consortium Wide in 2026



Rate of Baseline Form (P1/P2) Completion by Facility for 2026

Please drill through to see site specific details of Patients with or without baseline



2026 Prostate Quality Initiatives

RECOMMENDED ADT

MRI UTILIZATION

2026 Recommended ADT

Improve percentage of patients with intact, localized, high-risk prostate cancer patients receiving definitive radiotherapy that are recommended to receive long-term androgen deprivation therapy (ADT).

10 Points	≥65% of prostate cancer patients recommended to receive long-term ADT
7 Points	55-64% of prostate cancer patients recommended to receive long-term ADT
0 Points	<55% of prostate cancer patients recommended to receive long-term ADT

This measure is part of 2026 P4P|2027 Gold Card|2027 CQI VBR

ADT Recommendation Quality Measure for Prostate

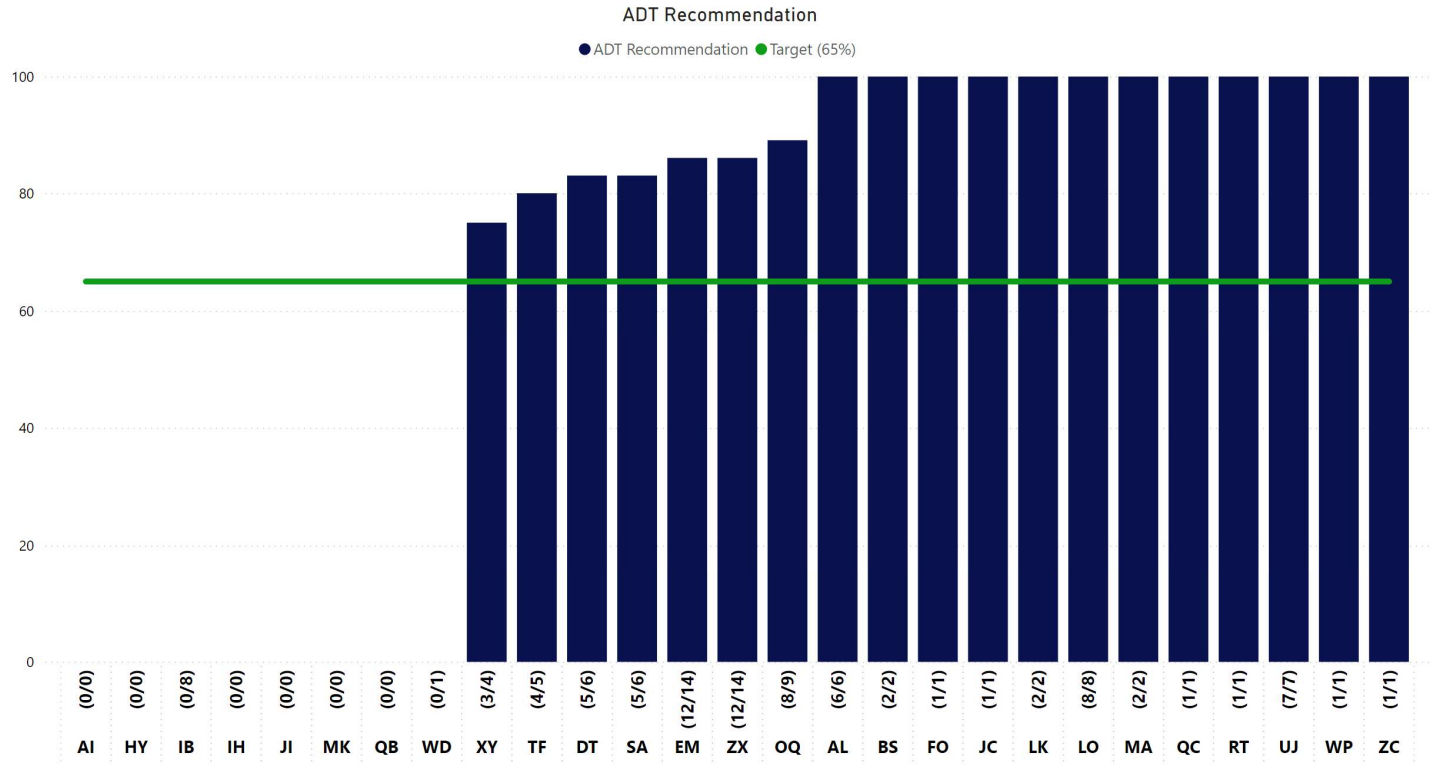
The 2026 Performance Period includes cases who started RT 01/01/2026-09/30/2026

Data Refreshed as of 05/01/2026

Measure Description:

Improve percentage of patients with intact, localized, high-risk prostate cancer receiving definitive radiotherapy that are recommended to receive long-term androgen deprivation therapy (ADT)

Full points: >=65% of prostate cancer patients recommended to receive long-term ADT
Partial points: 55-64% of prostate cancer patients recommended to receive long-term ADT
Zero points: <55% of prostate cancer patients recommended to receive long-term ADT



2026 MRI Utilization

Increasing MRI Utilization for Intact Prostate Cancer Patients Receiving Definitive Radiotherapy

10 Points	≥70% of prostate cancer patients received an MRI
7 Points	60-69% of prostate cancer patients received an MRI
0 Points	<60% of prostate cancer patients received an MRI

This measure is part of 2026 P4P|2027 Gold Card|2027 CQI VBR

MRI Utilization Quality Measure for Prostate

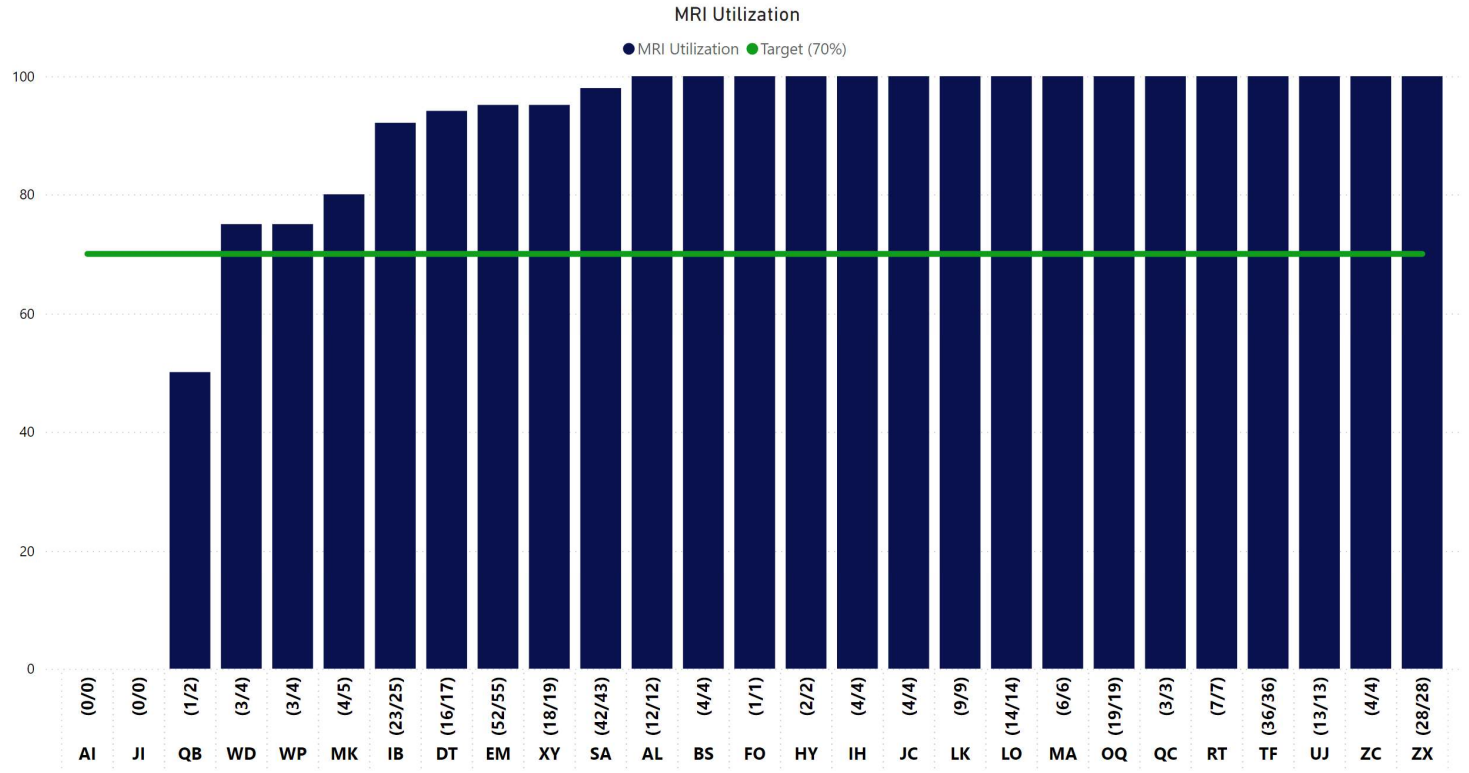
The 2026 Performance Period includes cases who started RT 01/01/2026-09/30/2026

Data Refreshed as of 05/01/2026

Measure Description:

Increase MRI utilization for intact prostate cancer patients receiving definitive radiotherapy

Full points: >=70% of prostate cancer patients received an MRI
Partial points: 60-69% of prostate cancer patients received an MRI
Zero points: <60% of prostate cancer patients received an MRI



Hot Topics: New Quality Measure(s)

MR QC
— PROSTATE WORKING GROUP —

Thank you!

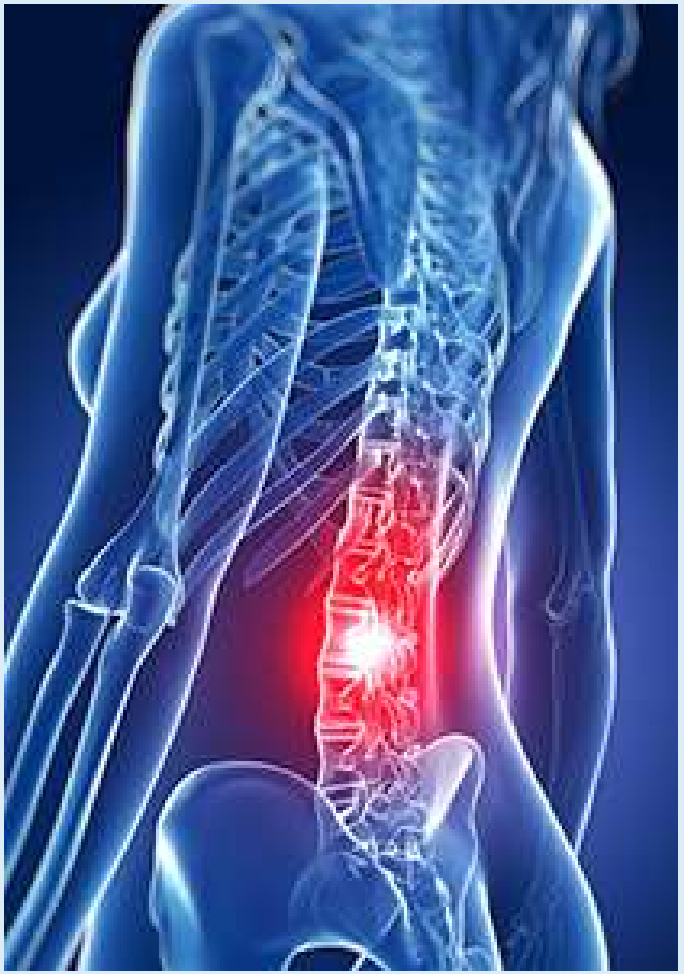
Our Next Working Group Meeting will be Tuesday, June 16th from 12-1 p.m. featuring guest, Tyler Seibert, MD, PhD

MR QC
— PROSTATE WORKING GROUP —

MROQC Mets Working Group Meeting

May 15, 2026

Donna Edwards, Eyad Abu-Isa, Lana Critchfield



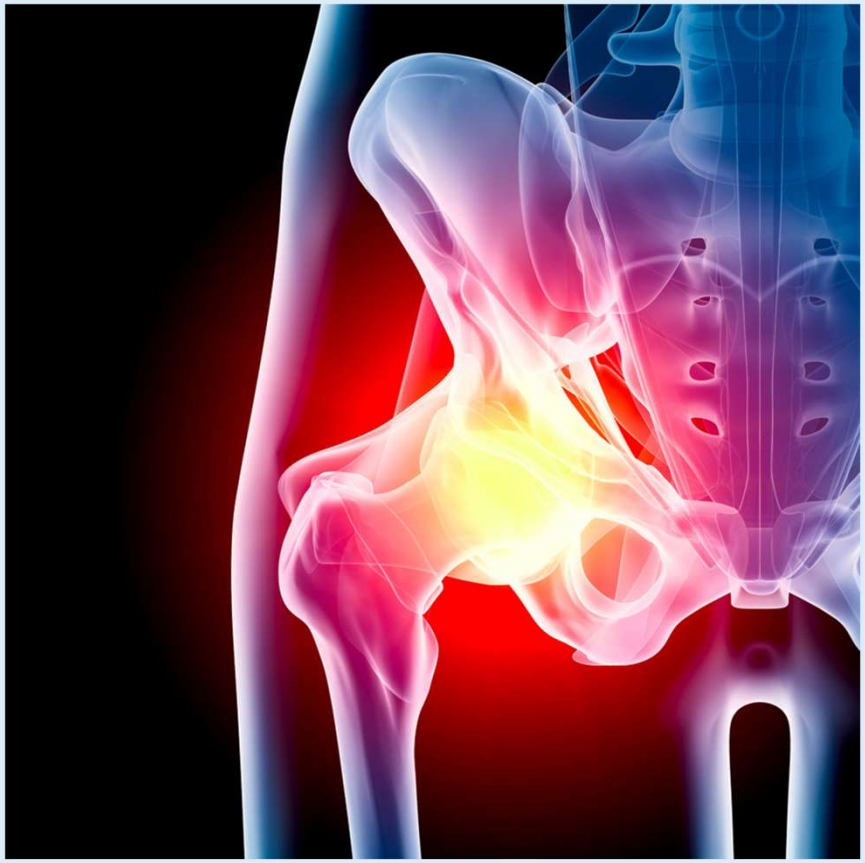
Today's Agenda

WORKING GROUP PERFORMANCE

2027 QUALITY MEASURE(S)

BRAIN METS FUTURE DIRECTIONS & DATA COLLECTION

Working Group Performance



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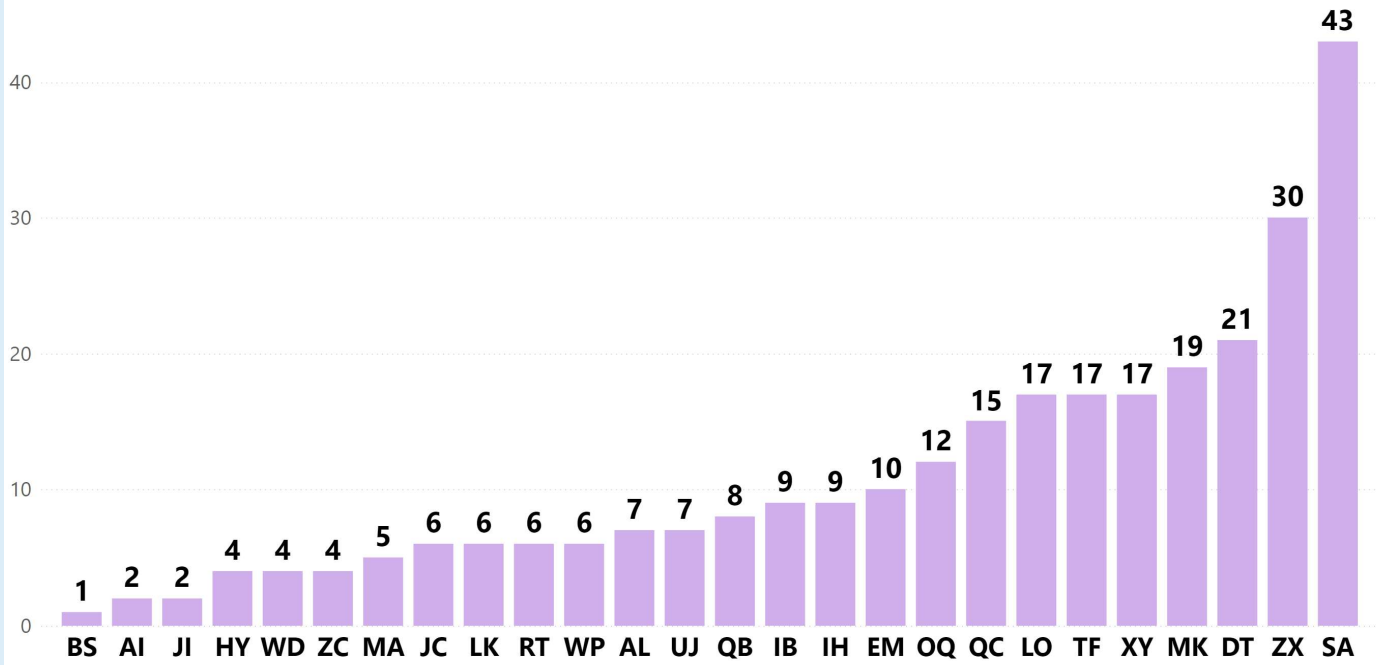
METS WORKING GROUP

ENROLLMENT FOR METS PROJECT

Date refreshed as of 5/1/2026

ENROLLMENT BY FACILITY

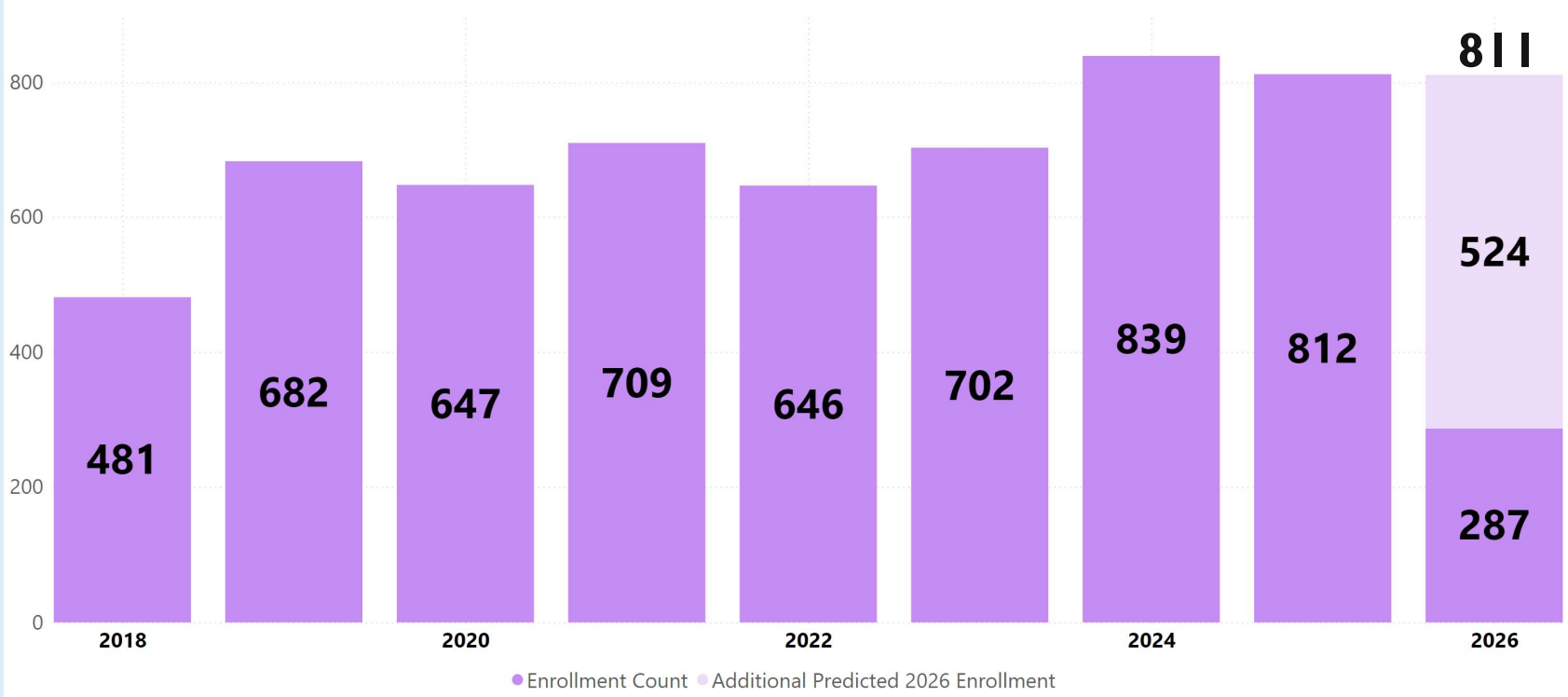


Facilities with no data

FO

ENROLLMENT FOR METS PROJECT

Date refreshed as of 5/1/2026



2026 Shorter Tx. Bone Mets Quality Measure

Increase the utilization rate of bone mets treatments consisting of 5 fractions or fewer.

10 Points	≥75% rate achieved
7 Points	60-74% rate achieved
0 Points	<60% rate achieved

This measure is scored per treatment course

MR QC
METS WORKING GROUP

This measure is part of 2026 P4P|2027 Gold Card|2027 CQI VBR

5 or Less Fractions Quality Measure for Bone Mets

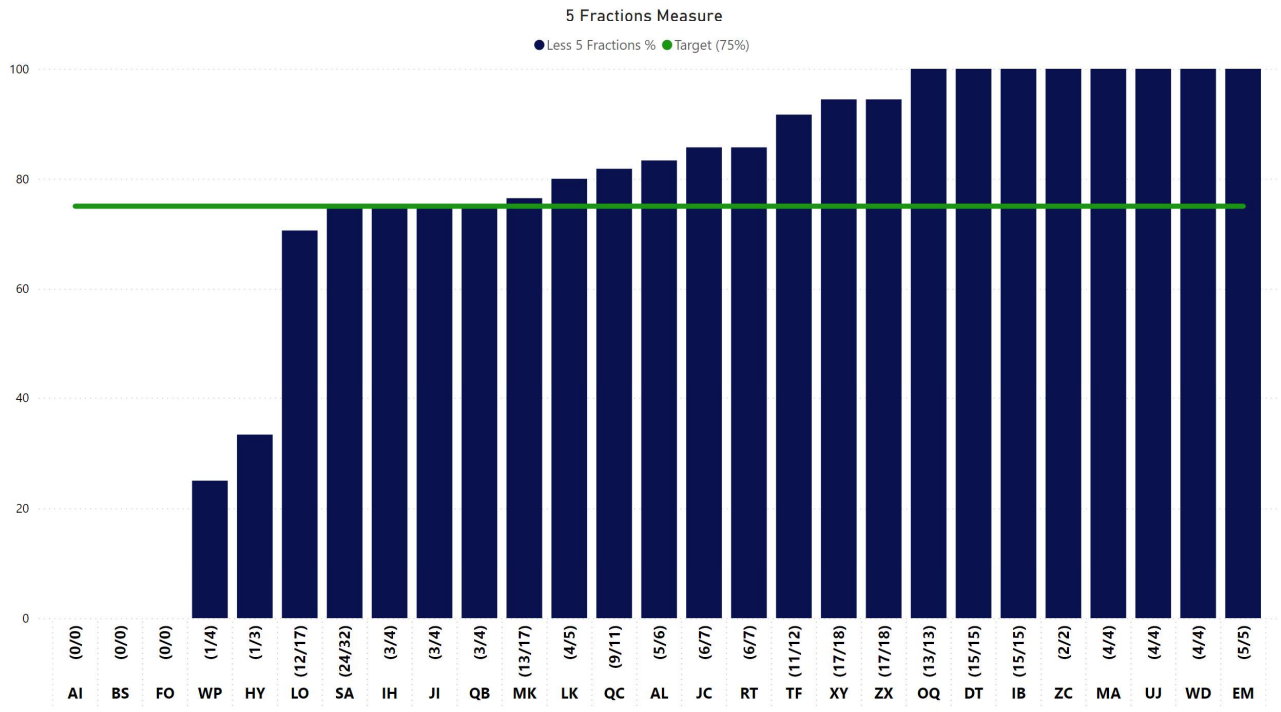
The 2026 Performance Period includes cases who started RT 01/01/2026-09/30/2026

Data Refreshed as of 05/01/2026

Measure Description:

Increasing the use of shorter course radiotherapy for bone metastasis as shown by use of <5 fraction treatment for at least 75% of patients

Full points: ≥75% rate achieved
Partial points: 60-75% rate achieved
Zero points: <60% rate achieved



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MROQC Publication Highlight
Advances in Radiation Oncology (2026)

Progress in Shortening Treatment Courses for Bone Metastases in a Statewide Quality Consortium

Luke Higgins, Huiying Yin, Kent Griffith, Jumoke Johnson-Olokesusi, Amit Bhatt, Kelly Paradis, Lana Critchfield, Eyad Abu-Isa, Kaitlyn Baldwin, Vrinda Narayana, Howayda Messiha, Jennifer Davis, Mohamad Fakhreddine, James Hayman

Key Findings

- Analysis included **4,477 patients** and **6,733 RT treatment plans** across the statewide consortium
- Use of **single-fraction RT** for uncomplicated bone metastases increased from **17.8%** → **38.8%** following implementation of quality measures
- Use of ≤**5 fraction RT courses** for bone metastases increased from **44.2%** → **63.9%**
- Demonstrates successful statewide adoption of shorter, evidence-based treatment approaches through collaborative quality improvement

Why It Matters

✓ Improved patient convenience

✓ Reduced treatment burden and travel

✓ Supports high-value, patient-centered care

✓ Demonstrates real-world impact of MROQC quality initiatives

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Published on behalf of the Michigan Radiation Oncology Quality Consortium (MROQC) as part of the BCBSM Value Partnerships Program

2026 Bone Mets Reirradiation Measure

Increase the rate of physics consultation for bone metastases reirradiation.*

**For cases where there is concern for toxicity due to cumulative dose (Type 1 or Type 2 reirradiation), the physics consult must occur prior to physician approval. For Type I reirradiation cases with no concern for toxicity, the consult must occur prior to the start of treatment.*

10 Points	≥50% documentation rate of a physics consult achieved by facility
0 Points	<50% documentation rate of a physics consult achieved by facility

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This measure will be part of 2026 P4P|2027 Gold Card|2027 CQI VBR

Physics Consult for Bone Mets Re-Irradiation Quality Measure

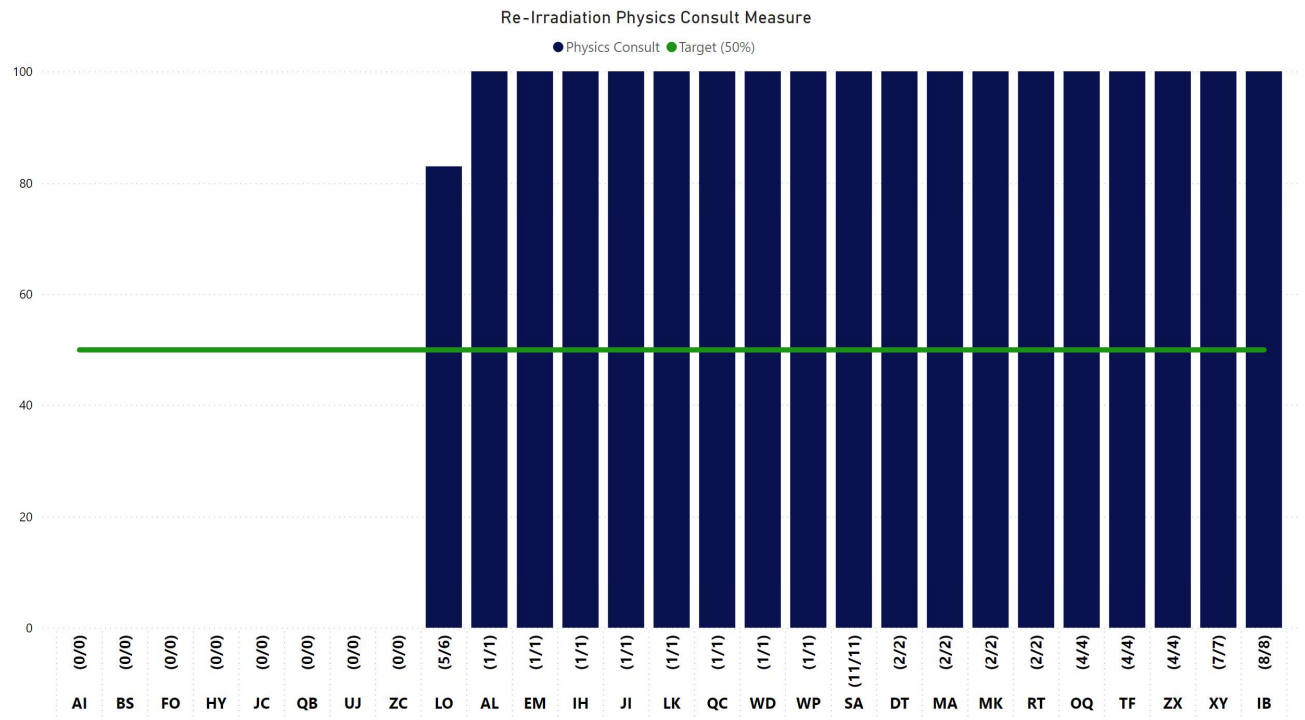
The 2026 Performance Period includes cases who started RT 01/01/2026-09/30/2026

Data Refreshed as of 05/01/2026

Measure Description:

For 50% or more of bone mets reirradiation cases, it is documented that physics was consulted before final physician approval of a plan for Type 1 reirradiation (Overlap of irradiation volumes with or without concern for toxicity from cumulative doses) OR Type 2 reirradiation (No overlap of irradiated volumes but concern for toxicity from cumulative doses)

Full Points: >=50% of bone mets reirradiation cases received a physics consult
Zero Points: <50% of bone mets reirradiation cases received a physics consult



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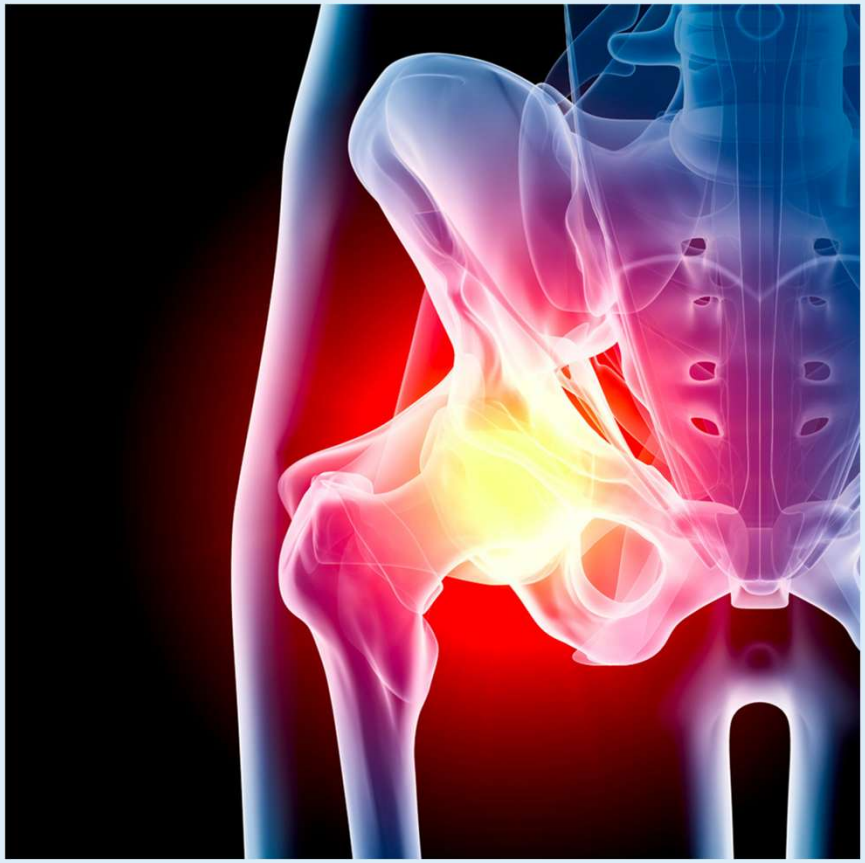
2027 Quality Measure(s)



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MROQC Mets Working Group: 2-Year Roadmap

2026: Focus & Foundation

Brain Metastases

- Draft data collection forms
- Expert-led discussions on:
  - Large/post-operative cases
  - SRS for 5–10 metastases
  - Dose metrics and toxicity
  - Case-based education and shared learning

Bone Metastases

- Define scope and key gaps in:
  - Reirradiation
  - SIM-free radiation
  - Inventory current practice patterns and barriers

2027 Alignment & Application

Brain Metastases

- Start enrollment to the project
- Develop consensus guidance and reference materials
- Identify opportunities for standardization *where appropriate*

Bone Metastases

- Advance reirradiation frameworks:
  - Patient selection
  - Cumulative dose considerations
- Explore best practices for SIM-free workflows

Start with shared understanding-build toward alignment.

Future Updates to Reirradiation Documentation

Reirradiation Collaborative Group (ReCOG) consensus on standards for dose evaluation and reporting in patients with multiple courses of radiation therapy: an AAPM/ACRO/ASTRO/CARO/COMP/CADRA/CPQR/ESTRO/NRG-endorsed consensus statement

Kelly C Paradis, Ane L Appelt, Soren M Bentzen, Nick Chng, Elizabeth L Covington, Laura A Dawson, Dorota Gabryś, Dwight E Heron, Lone Hoffmann, Andrew Jackson, Lawrence B Marks, Charles Mayo, Kilian E Salerno, Charles B Simone 2nd, Ying Xiao, Ellen Yorke, Philip Poortmans, Jeffrey C Buchsbaum**

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Documentation standards for reRT when there is no concern for side-effects

Recommended standard

1 Previous and current radiation anatomical treatment sites (including laterality, where applicable), treatment dates, and the reason there was no concern (eg, low cumulative doses or non-overlapping)

Documentation standards for reRT when there is concern for side-effects

Recommended standards, as applicable and achievable†

1 Previous and current radiation anatomical treatment sites (including laterality, where applicable), target prescription doses, treatment techniques and modalities‡, and treatment dates
2 Any radiobiological parameters applied, if applicable (eg, α/β, radiobiological effectiveness, TRF)
3 Method(s) used to register imaging datasets
4 Method(s) used to calculate cumulative dose
5 Evaluation of uncertainties in the dose accumulation process§
6 OAR-specific, dose–volume histograms-based dose metric estimates, dose type as specified:

Previous relevant treatment(s)	Physical
Current treatment(s)	Physical
Cumulative dose	Equieffective
Cumulative dose with TRF (if applicable)	Equieffective

7 Patient informed consent for reRT risks, documentation of shared decision making, and discussion of alternative treatment strategies considered[26]

Optional standards, as applicable

1 Visual documentation of the degree of overlap between relevant treatment plans, such as with axial, coronal, and sagittal colour dose images centred on clinically relevant regions and normal tissues
2 Cumulative equieffective dose–volume histograms for relevant organs at risk

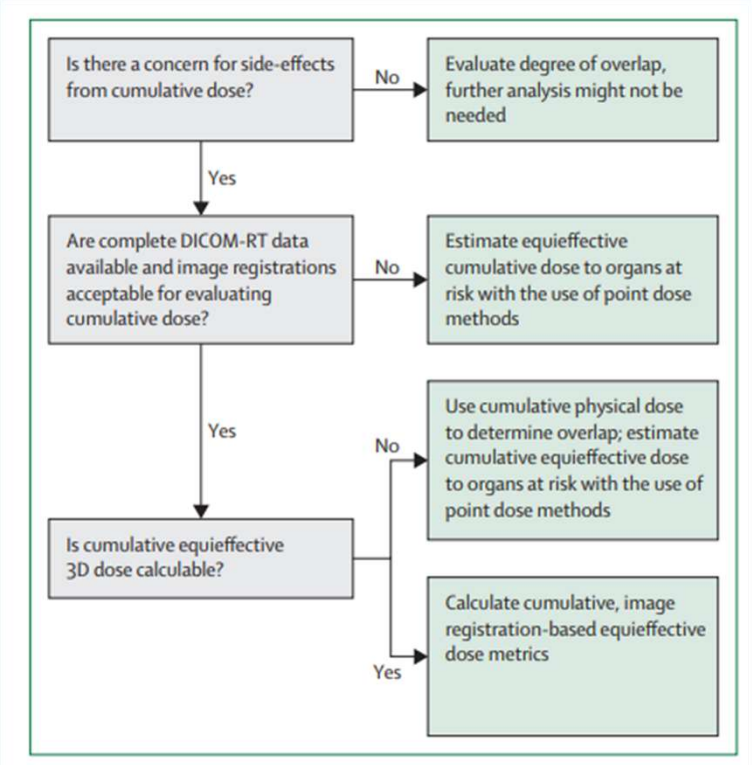
For research cohorts only

Recommended standard

1 Whenever possible, report patient-specific, per-plan, and cumulative 3D dose and/or cumulative dose–volume histogram data including uncertainties¶

Future Updates to Reirradiation Documentation

- Dose Assessment Recommendations



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Future Updates to Reirradiation Documentation

Current Measure:

Increase the rate of physics consultation for bone metastases reirradiation.*

**For cases where there is concern for toxicity due to cumulative dose (Type 1 or Type 2 reirradiation), the physics consult must occur prior to physician approval. For Type I reirradiation cases with no concern for toxicity, the consult must occur prior to the start of treatment*

Adjusted Measure:

Increase the rate of recommended dose assessment and documentation for bone metastases reirradiation

- Change "toxicity" to "side-effects", remove language about Type 1 and Type 2
- Remove "must occur prior to start of treatment"

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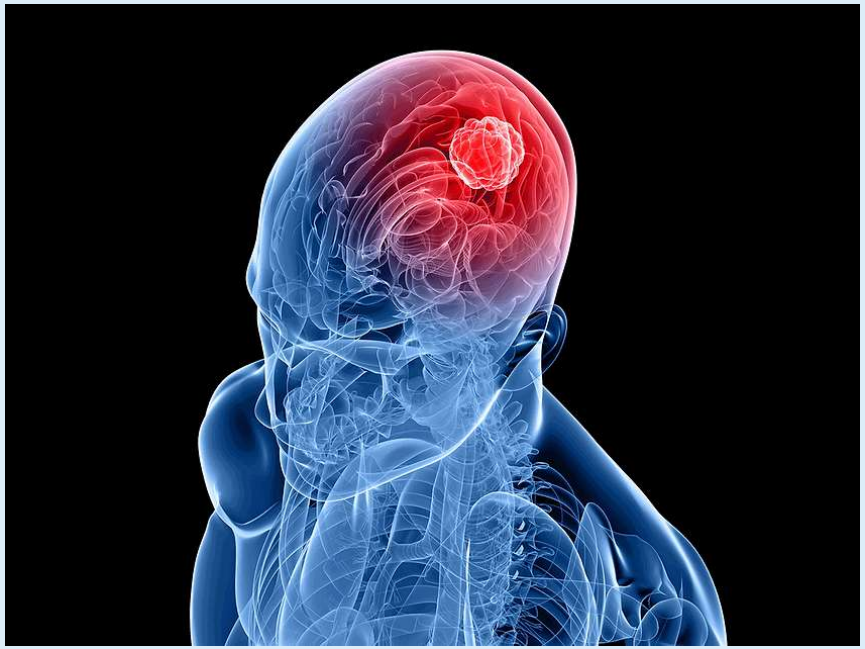
Brain Mets Future Directions & Data Collection



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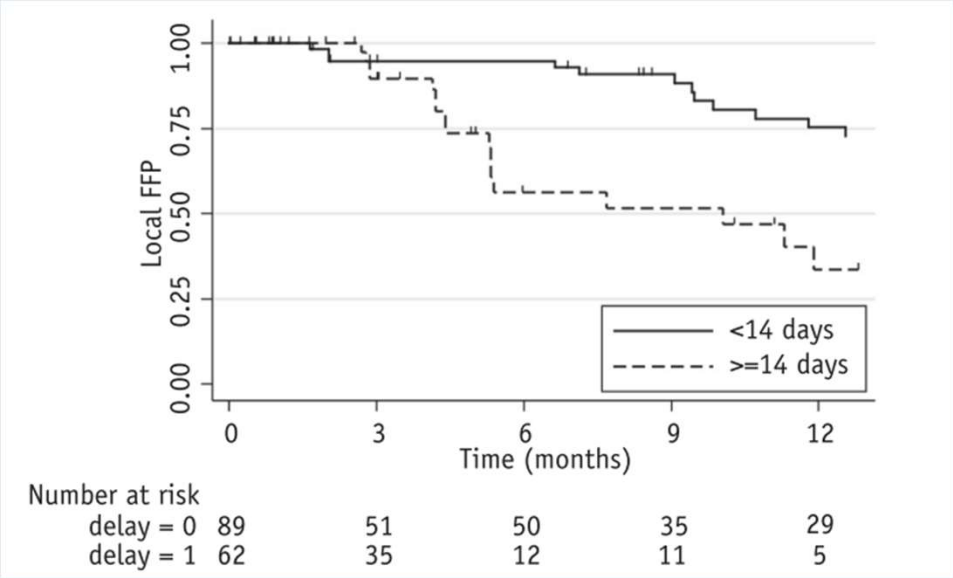
Starting Focus Areas

Quality of Treatment Delivery for Brain Mets Patients

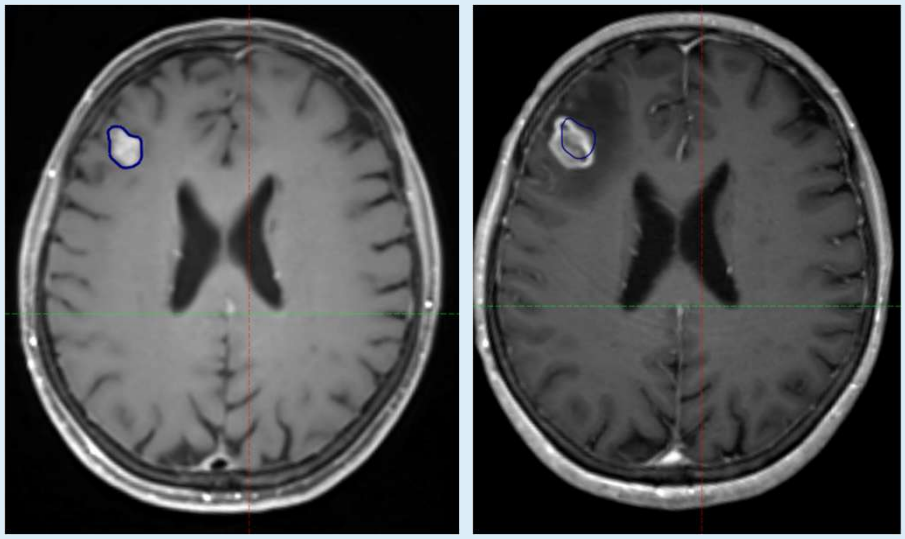
- Pretreatment MRI: sequences utilized, timing between scan and delivery

NCCN recommends interval between MRI to treatment <= 2 weeks



Seymour et al 2014 IJROBP

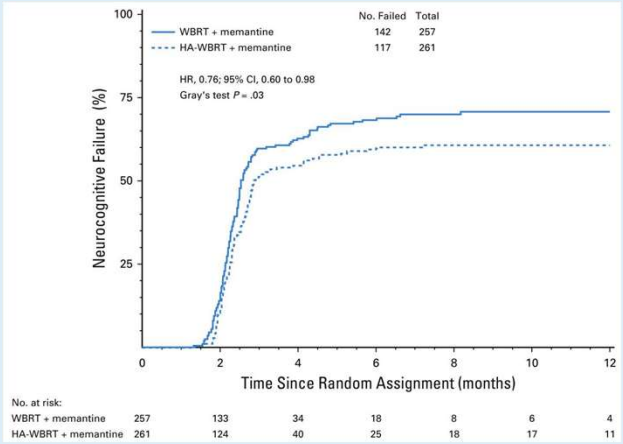
Day 1 Day 13



Starting Focus Areas

- **Quality of Life** for Patients: **Neurocognitive Preservation**

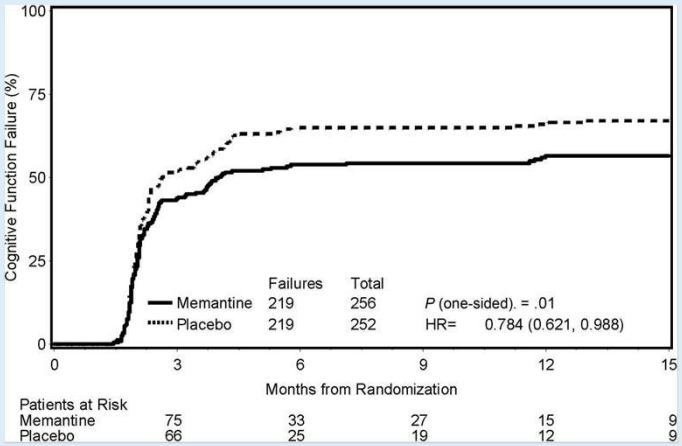
- Utilization and quality of HA-WBRT



NRG CC001

HA-WBRT preserved cognitive function compared to WBRT

- Real world utility/implementation of memantine?



RTOG 0614

memantine delayed time to cognitive decline

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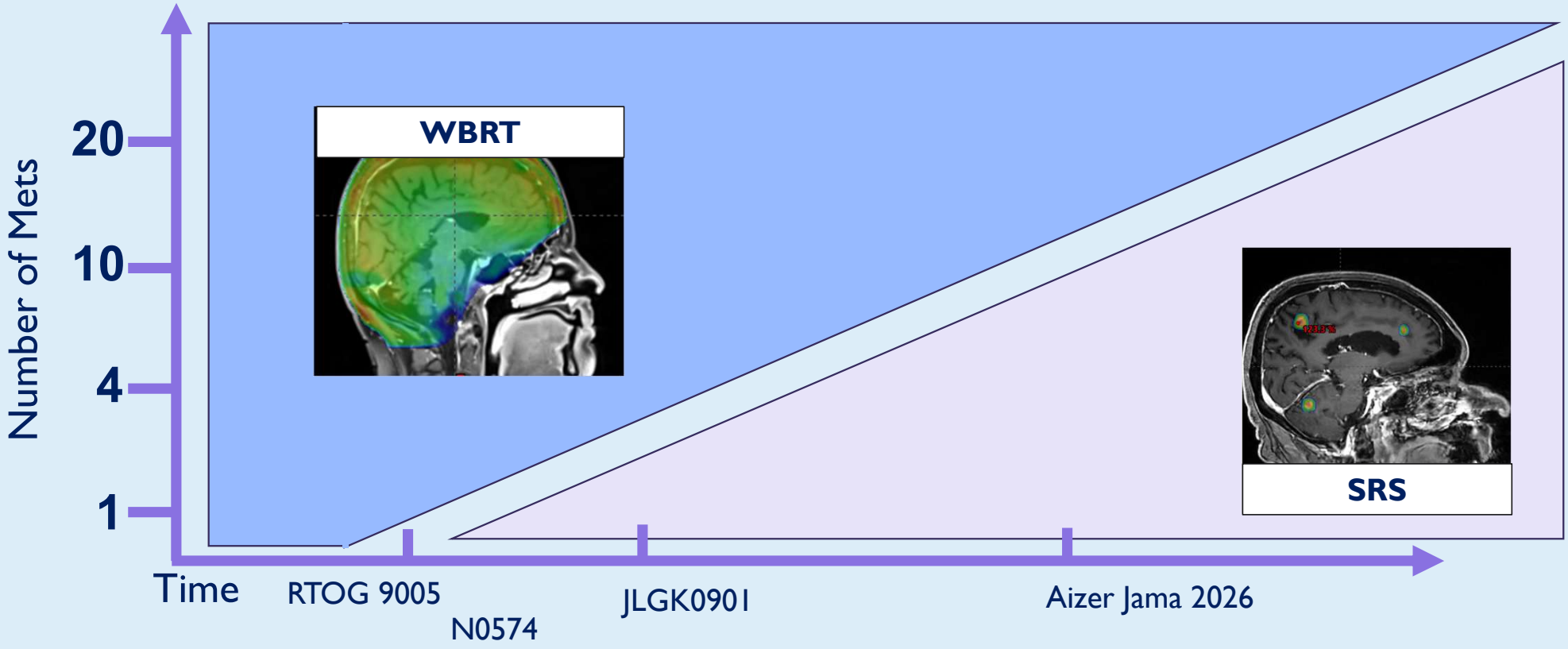
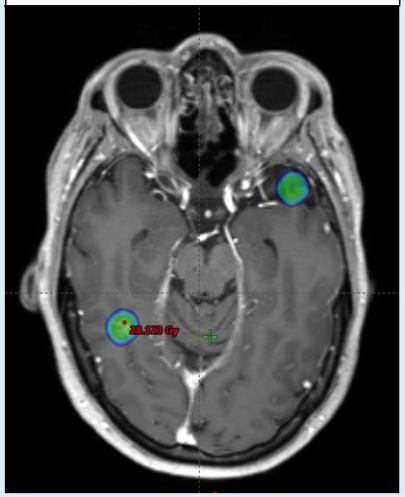
Starting Focus Areas

- **Quality of Life** for Patients: **Neurocognitive Preservation**
  - Minimizing treatment footprint (number of mets influencing decision for SRS vs HA-WBRT)

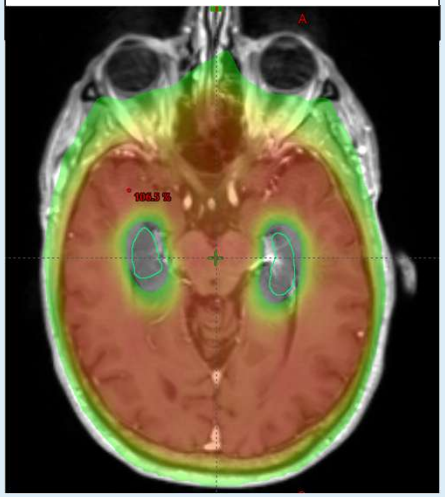


Brain Mets-Exclusion Criteria

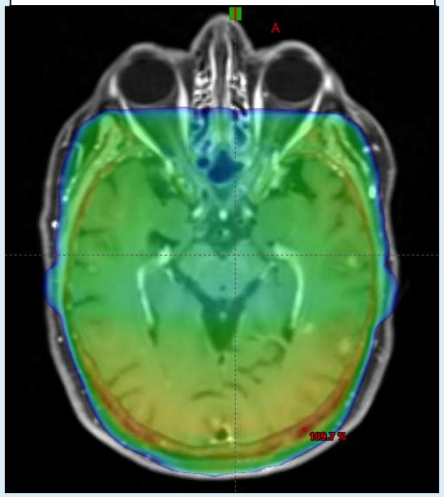
SRS (fSRS)



Hippocampal avoidant Whole Brain RT



Whole Brain RT



Exclusion Criteria

- age <18
- leptomeningeal disease (as defined per ESTRO guidelines), or suspicion thereof by treating physician
- primary cancer diagnoses of small cell lung cancer or non-solid tumors (hematologic malignancies such as multiple myeloma, lymphoma, leukemia)
- patients unable to undergo regular MRIs (claustrophobia requiring anesthesia, pacemaker)

Overview of Forms

- One-time physics form for each site (not needed for each patient): capturing general details of treatment (immobilization, treatment planning etc)
- Will create repeat treatment/same patient form (ie frequent flier form—eliminating repeat baseline information)

Baseline:

- Clinical physician form
- Clinical CDA form
- Patient/caregiver PRO

Treatment details: physics form

3 months (likely correlated to follow up visit)

- Brief Physician form (CTCAE toxicity, NANO)
- Brief CDA form
- Patient/caregiver PRO

1 year (not tied to clinical visit, just chart review)

- Physician form (Cancer related treatment outcomes, necrosis, etc)

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PROs

- Unique population—they have **significant QoL impacts** from their disease; may not directly be able to engage in PROs (due to cognitive impairment) and so we are proposing **caregiver** forms

- We follow these patients **more closely** than bone mets, so believe this data will be able to be captured (most will have a 2-3 mo post RT visit, so we are proposing baseline and 3 mo)

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Physics Forms

- Initial Mets Program Questionnaire
- Individual Patient
  - Dicom upload: MR (T1-weighted post contrast), RT Plan, RT Dose, RT Structure Set
  - Physics Form: Diagnostic Imaging, Simulation, Treatment Planning, Treatment Delivery

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Feedback Wanted!

Brain Mets Baseline Clinical Data Forms

Institutional Questionnaire and Physics Brain Mets Form

MR QC
METS WORKING GROUP

Join Us!

Our next meeting will be on

Monday, June 22nd

from 3:00-3:30 p.m.

M-EQUAL UPDATE

Renu Sharma, MS

5/15/2026

AGENDA

PERFORMANCE METRIC REVIEW

2026 GOALS

MR QC
— M-EQUAL —

2026 CANNABIS EDUCATION VBR MEASURE

Measure: At least **80%** of breast cancer patients who report using cannabis in the past 30 days are offered an MROQC cannabis education document during treatment

Patients Included: Breast cancer patients beginning treatment between January 1, 2026, and September 30, 2026, who report cannabis use within the 30 days prior to their treatment start date.

Incentive Program: CQI –VBR

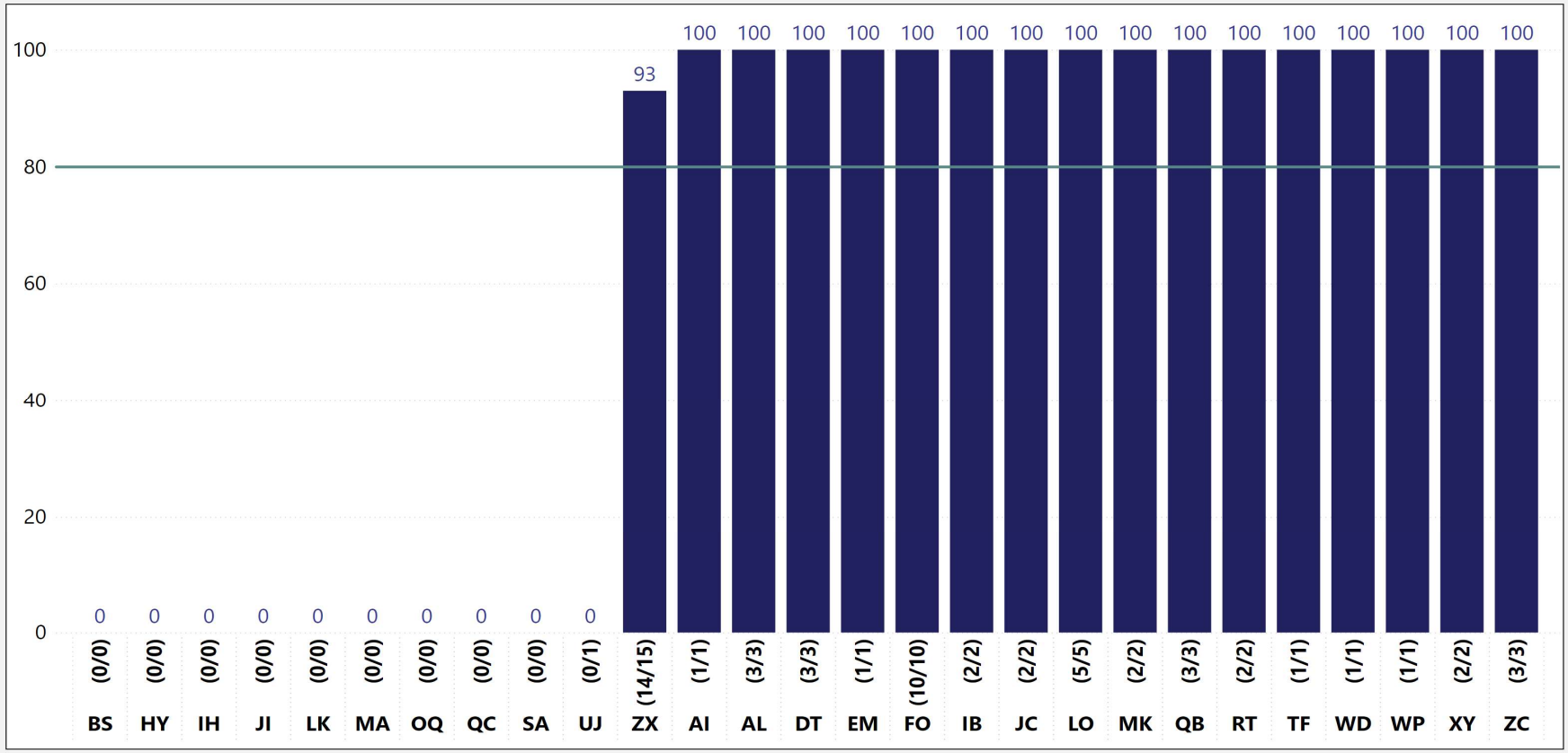
Cannabis Education For All Facilities in 2026

Associated Incentive Program: CQI VBR

DATA UP TO DATE AS OF 05/04/2026

Measure Description: **At least 80% of breast cancer patients who report using cannabis in the past 30 days are provided an MROQC cannabis education document during treatment**

Full Points: >=80%



2026 M-EQUAL PRIORITIES

Race Data Comparison

Comparing abstractor-recorded and patient-reported race data to evaluate consistency across facilities, with findings targeted for abstract submission.

Social Needs Data Expansion

Exploring new screening questions around food insecurity, transportation, and housing to better understand patient barriers to care.

Community Partnerships

Building connections with organizations like 2-1-1 and the Michigan Department of Health to link patients with resources and support.

GET INVOLVED WITH M-EQUAL

We want to hear from you

Have feedback on our priority areas? Interested in contributing to one of our 2026 projects? We welcome input from across the collaborative

Join the Committee

MROQC is committed to identifying and addressing gaps in care experienced by our patients, and M-EQUAL leads that work. We meet bi-monthly and welcome members from all roles and all facilities.

ROQCSTAR REPORT

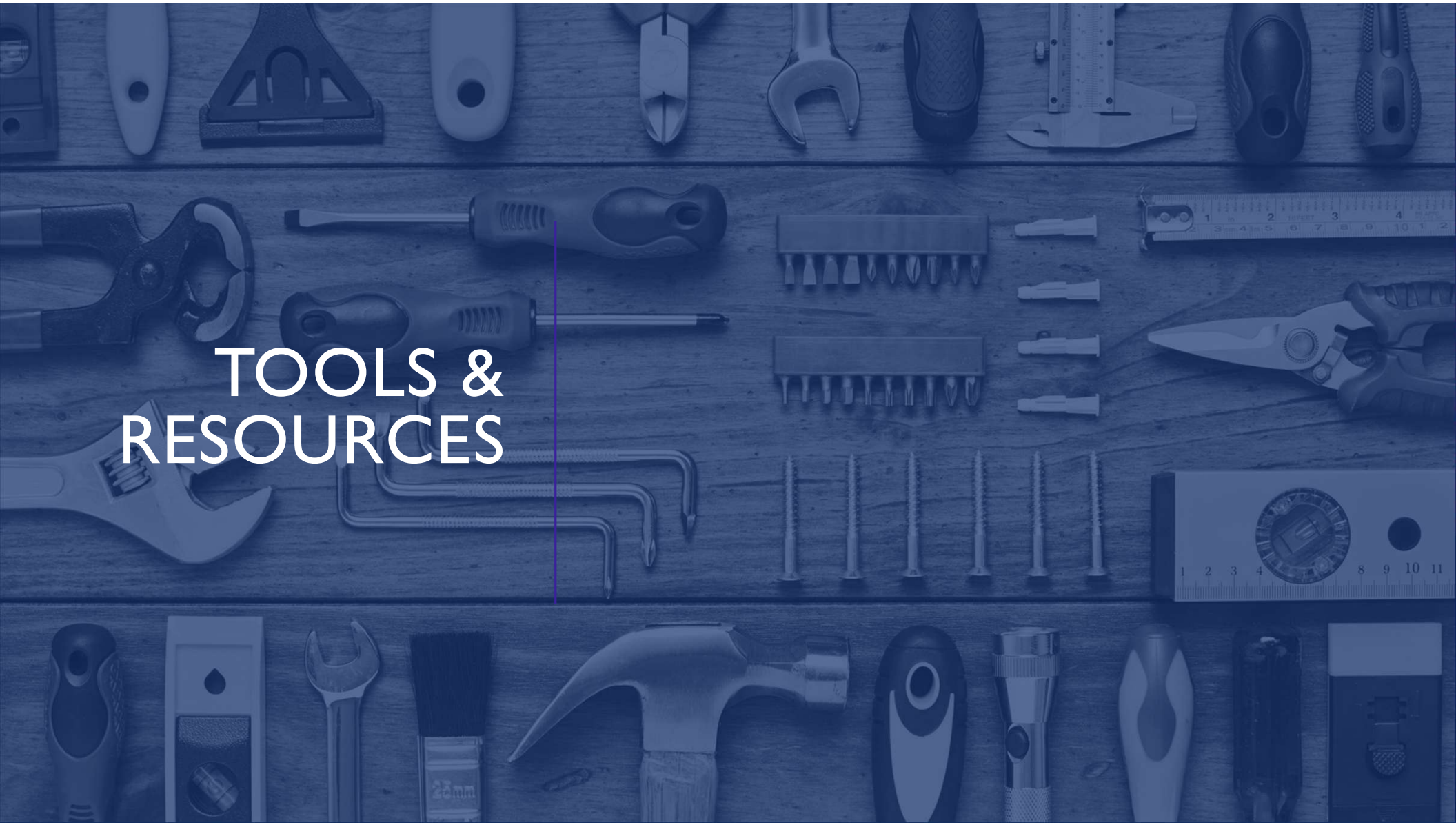
Melissa Mietzel, MS

May 15, 2026

Tools &
Resources

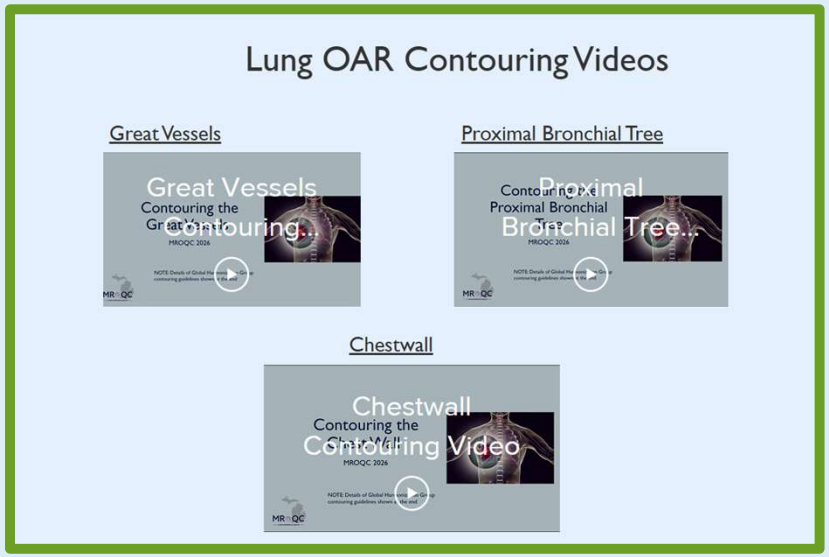
ROQCstar
Awards

TODAY'S REPORT



TOOLS & RESOURCES

New MROQC Lung Contouring Resources



MROQC has developed new OAR contouring training videos for Lung treatment planning

Goal

- Promote consistent contouring practices across the collaborative
- Support treatment planning and quality improvement

Access the Videos

Available on the MROQC website:

🔗 www.mroqc.org/lung-resources

MRQC
LUNG WORKING GROUP


ABOVE &
BEYOND
ROQCSTAR
AWARDS

ABOVE & BEYOND ROQCSTAR AWARDS

Celebrating Excellence Across MROQC

Recognizing individuals and teams who have gone above and beyond through:

- Outstanding collaboration
- Commitment to data quality
- Innovation & problem-solving
- Member support & engagement
- Special project contributions
- Dedication to improving patient care across Michigan

Thank You for Making MROQC Stronger Together

Award recipients will be invited to the front as their names are announced

CLINICAL DATA QUALITY CHAMPION AWARD

Recognizes facilities demonstrating a strong commitment to data quality through consistent abstraction accuracy, timely follow-up, and overall performance on clinical data quality review processes.

- Munson CDA Team
- Amber Tucker, WMCC
- Brenda Havey, McLaren Northern
- Genesys Hurley CDA Team
- Sarah Paluch, Covenant HealthCare
- Trinity Health Saint Mary's CDA Team
- Kathy Lapansie, Henry Ford St. John Hospital

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SUPPORT ROQCSTAR AWARD

Recognizes a CDA who consistently engages with support, asks thoughtful questions, and helps improve data quality through proactive communication and problem-solving.

- PJ Hensley, Michigan Medicine
- Jen Davis, Munson
- Doris Ethier, Genesys Hurley
- Jordan Parisian, Trinity Health Mercy Muskegon

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COLLABORATION IN ACTION AWARD

Recognizes CDAs who consistently engage with the MROQC team by contributing in working group meetings, sharing feedback, asking questions, and helping improve workflows and processes.

- Michigan Medicine CDA Team
- Liza Morris, MyMichigan
- Jasmine Bumpus, McLaren Greater Lansing
- Munson CDA Team
- Henry Ford Providence CDA Team

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MICHIGAN RADIATION ONCOLOGY QUALITY CONSORTIUM

SUSTAINED PHYSICS DATA QUALITY AWARD

Excellent mid-year data quality
(physics data quality rate of 100% as of 5/1/26)

- McLaren Bay Region
- UM Health-Sparrow
- Trinity Health Mercy Muskegon
- Covenant HealthCare
- McLaren Northern
- Henry Ford Jackson
- Henry Ford St. John

MRQC
MICHIGAN RADIATION ONCOLOGY QUALITY CONSORTIUM

PHYSICS HDR RETROSPECTIVE SPECIAL PROJECT AWARD

Special effort to submit retrospective HDR DICOM data

- Michigan Health Professionals
- Henry Ford Warren

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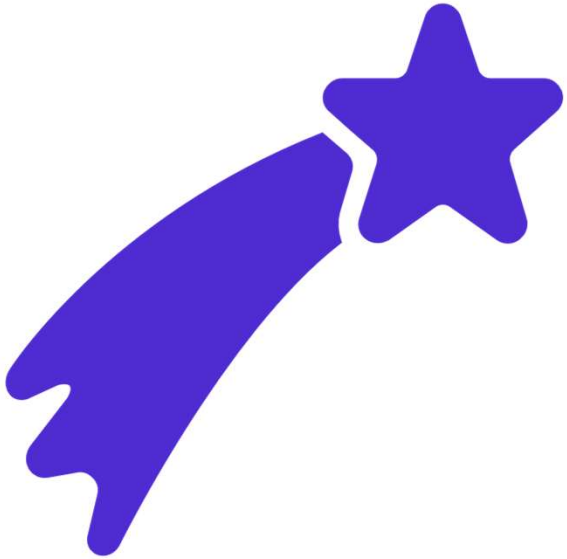
TG-263 ROQCSTAR AWARD

Most consistent use of TG-263 nomenclature

MyMichigan Midland

MRQC
MICHIGAN RADIATION ONCOLOGY QUALITY CONSORTIUM



CONGRATULATIONS!

LUNCH

Enjoy!!!

Breakouts will begin at 1:30 p.m.

Breakout Locations:

- Physician & Facility Administrators *Main Room*
- Physics & Dosimetry *55 ALPHA*
- CDA *40 GAMMA*

MR QC

MICHIGAN RADIATION ONCOLOGY QUALITY CONSORTIUM

CLOSE

May 15, 2026

THANK YOU FOR ATTENDING TODAY'S MEETING!

SPECIAL THANKS!

REMINDER FOR PHYSICIST CAMPEP CREDIT

If you plan to claim CAMPEP credit, please be sure to submit the Program Evaluation and Speaker Evaluation before leaving today's meeting.

Documentation must be submitted **today** to receive credit.

POST-MEETING SURVEY

Please take the MROQC Post-Meeting Feedback Survey

PLEASE RETURN YOUR BADGE AS YOU EXIT THE MEETING

REGISTRATION

2026 SUMMER SCHOOL

ADAPTIVE RADIOTHERAPY: Transforming Technology, Modern Practice, and Clinical Impact

JUNE 16–20 | UNIVERSITY OF MICHIGAN

IN-PERSON WITH ON-DEMAND ACCESS

- Admission to Didactic Sessions
- Breakfast, Lunches, Dinner & Breaks
- One (1) Summer School T-Shirt
- One (1) Proceedings Book
- On-Demand Recordings of Sessions
- Ability to Earn Continuing Education Credits

REGISTRATION CATEGORIES

- Full
- General/Affiliate
- Full-Lifetime
- Associate
- Associate-Student
- Resident of Low/Low-Middle Income Country (LMIC)

REGISTRATION & HOUSING OPEN:
MARCH 9, 2026

Early Bird Registration Deadline:
May 18, 2026

LEADERSHIP

2026 SUMMER SCHOOL

ADAPTIVE RADIOTHERAPY: Transforming Technology, Modern Practice, and Clinical Impact

JUNE 16–20 | UNIVERSITY OF MICHIGAN

SUMMER SCHOOL

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MROQC

SAVE THE DATE

15 Years

of Collaboration, Innovation, and Statewide Impact

2011 — 2026

🎉 Anniversary Celebration

Recognizing the people and partnerships that built MROQC

🚀 Future of RT

AI, innovation, and emerging applications of radiation therapy

🤝 Looking Ahead

Helping shape the next chapter of quality improvement together

Celebrating the past. Defining what's next.

Friday, October 30, 2026 • VistaTech Center | Schoolcraft College

THANK YOU!!!

MROQC ROQCstars:

- Patients
- Clinical Champions
- Facility Administrators
- Physicists & Dosimetrists
- Clinical Data Abstractors
- Participating Physicians
- Coordinating Center

Blue Cross Blue Shield of Michigan Value Partnerships Program

For more information: www.mroqc.org

Contact us: support@mroqc.org

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