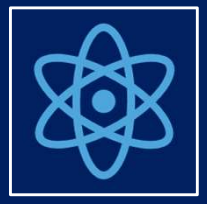
MR QC

MICHIGAN RADIATION ONCOLOGY QUALITY CONSORTIUM

CLINICAL CHAMPION PARTICIPATING PHYSICIAN FACILITY ADMINISTRATOR BREAKOUT

February 12, 2026

TODAY'S AGENDA

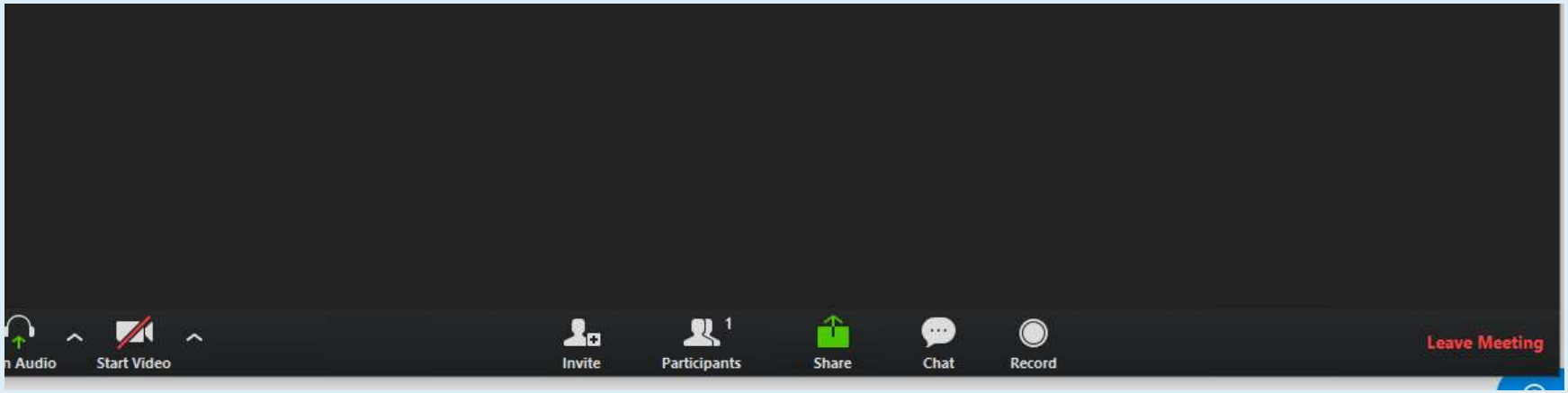


Updates from the Coordinating Center

MROQC: Future Directions Update

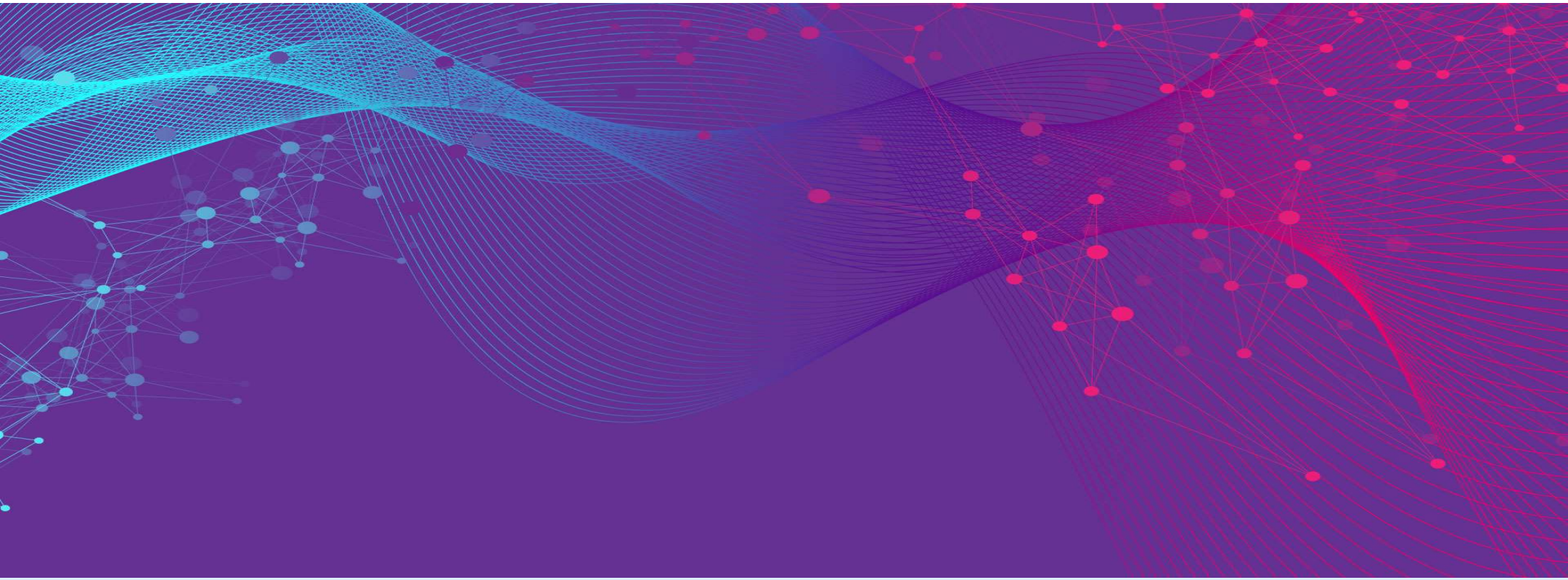
Q & A

ZOOM MEETING HOUSEKEEPING



Please rename yourself to your full name (i.e. *Rad Onc*)

- Click on Participants icon
- Hover over your name (or phone number, if you are just calling in)
- Click More → Rename
- Please mute yourself (don't worry-you'll be able to unmute to chat)



UPDATES FROM THE COORDINATING CENTER

Melissa Mietzel, MS

NEW MROQC WORKING GROUP LEADERSHIP

Welcome to our new Working Group Clinical Co-Leads!

Dr. Garth Tormoen, MD PhD
West Michigan Cancer Center
MROQC Lung

Dr. Donna Edwards, MD PhD
Michigan Medicine
MROQC Mets

MROQC WORKING GROUPS: POST-MEETING MATERIALS POLL

Q1: Which best describes your connection to MROQC working group meetings?

Q2: Do you currently receive slides and/or minutes from working group meetings?

Q3: How do you personally use post-meeting materials (slides and/or minutes)?

Q4: If MROQC were to adjust how post-meeting information is shared, which option would be most useful to you?

BCBSM BIENNIAL CQI SURVEY

A quick ask from MROQC leadership

You should have received a separate email with the survey link

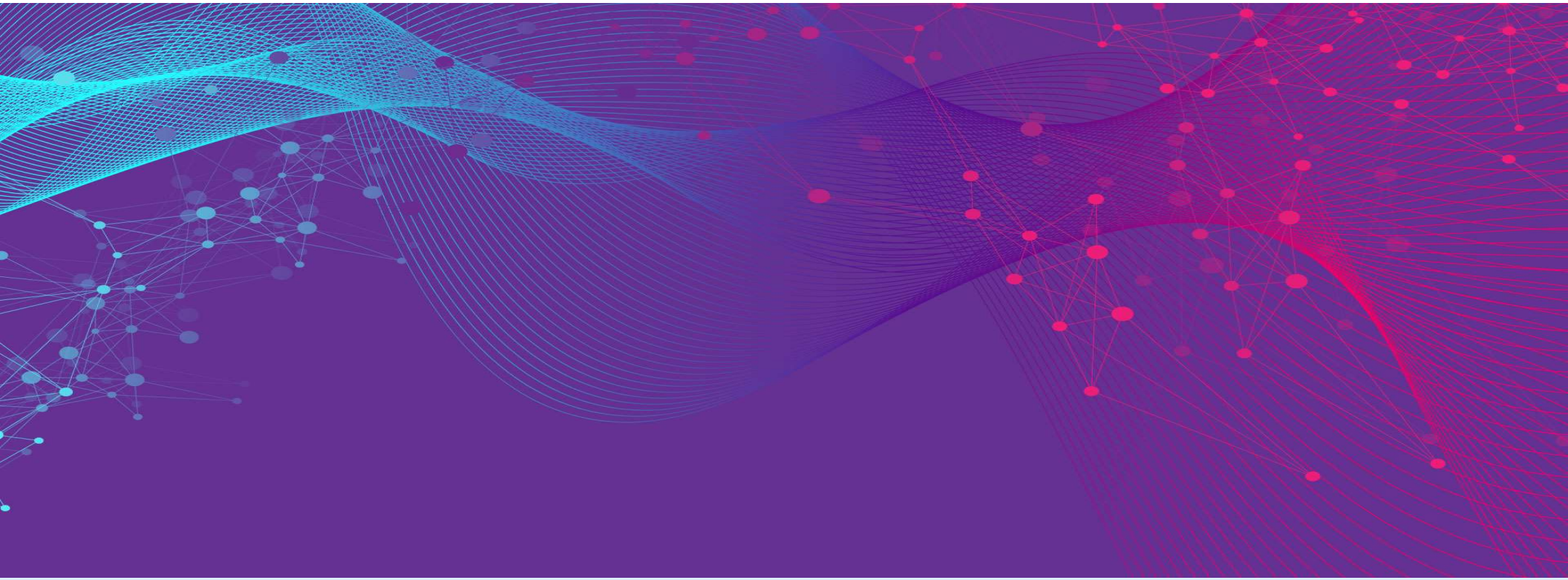
- BCBSM requires CQIs to distribute this survey
- **All responses go directly to BCBSM**
- 🔒 **Responses are 100% anonymous to MROQC**
- MROQC receives **only a de-identified summary report**

Why your response matters

- BCBSM uses this survey to evaluate MROQC's value and support
- **Response rates matter-**low participation limits how results are interpreted
- Your feedback helps shape future resources and support for **MROQC facilities**

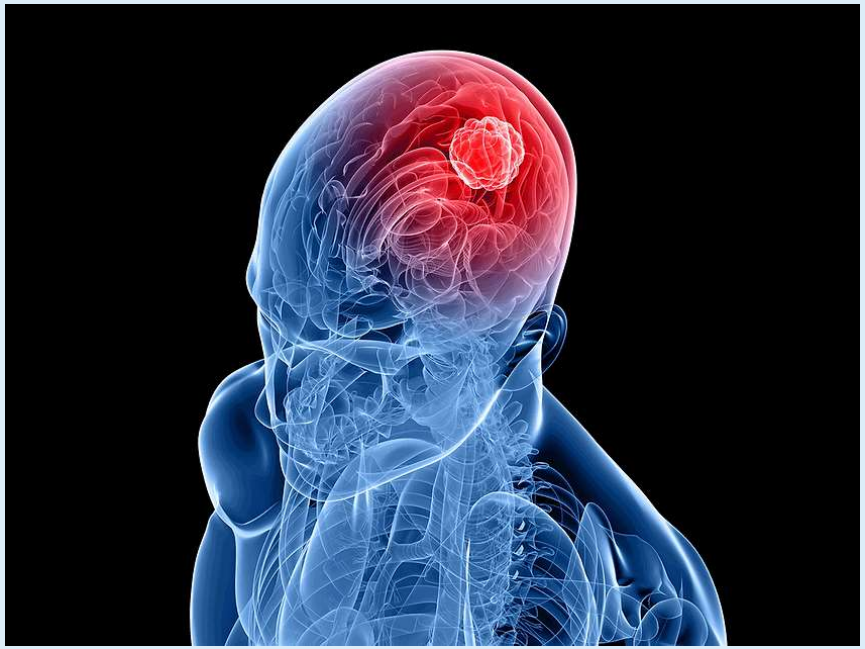
🕐 **~10 minutes**

🗓️ **Deadline: Monday, February 23, 2026**



STATE OF MROQC: FUTURE DIRECTIONS UPDATE

MROQC Mets Quality Improvement Working Group: Brain Mets Survey Results



Drs. Eyad Abu-Isa, Donna Edwards, and Lana Critchfield

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Survey Overview & Purpose

MROQC-wide survey of radiation oncologists on brain metastases care

Goal: identify alignment, barriers, and high-value focus areas for MROQC

Focus on real-world practice, not hypothetical scenarios

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Who Responded

- Broad representation across MROQC facilities (88% response rate)
- Wide range of years in practice
- Most treat ≥10 brain metastasis patients/year
- Near-universal access to SRS/SRT and HA-WBRT

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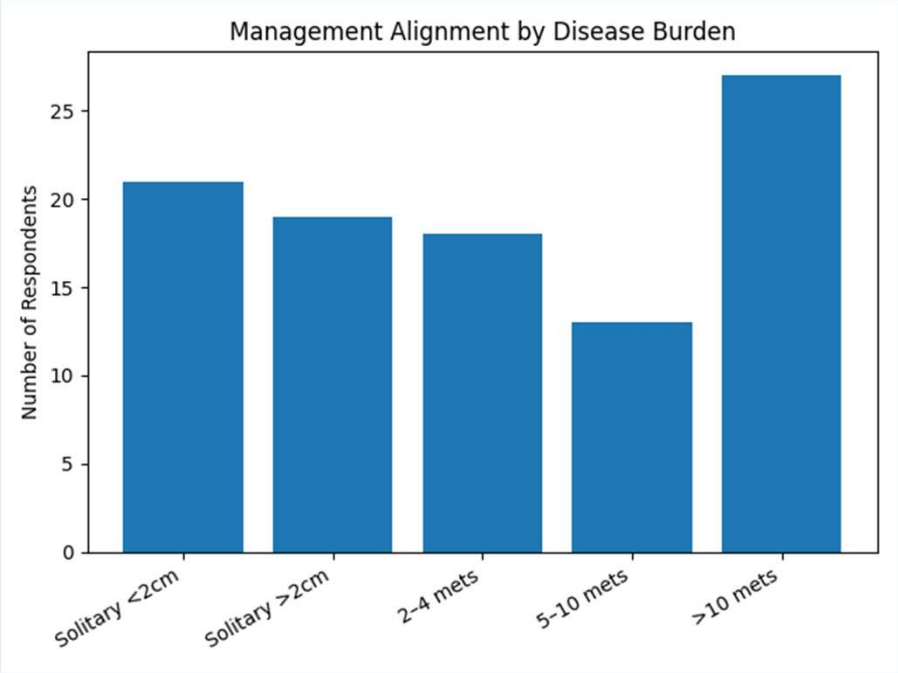
Areas of Strong Alignment

- Solitary <2 cm: SRS predominant
- 2–4 metastases: SRS/SRT predominant
- >10 metastases: WBRT (often hippocampal-avoidant + memantine)
- High adoption of HA-WBRT and memantine



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Where Practice Diverges

Solitary >2 cm lesions

Patients with 5–10 brain metastases

Variation reflects evolving evidence and technology constraints

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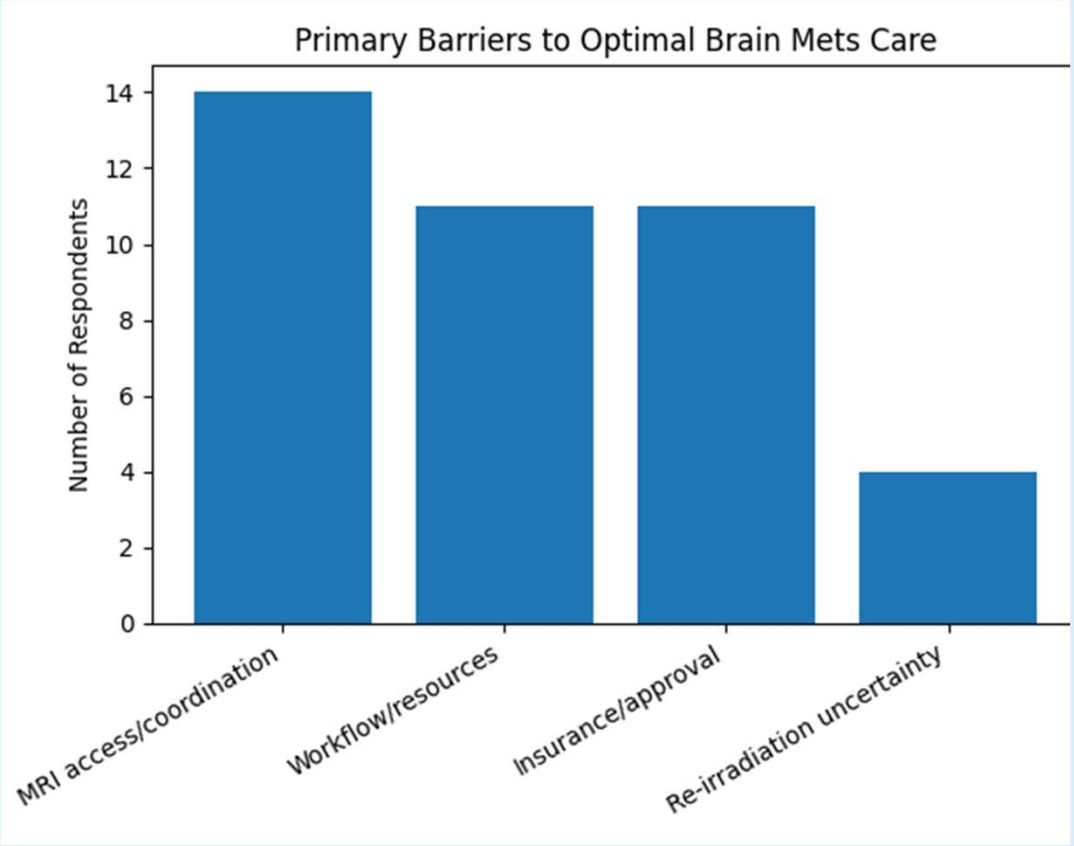
Barriers Are Mostly Structural

MRI access and coordination

Workflow, time, and resource constraints

Insurance/approval delays

Uncertainty around re-irradiation and normal brain constraints



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Guidelines Are Used and Trusted

- Most follow NCCN, ASTRO, and SNO guidelines
- Very few report difficulty implementing them
- Gaps remain in applying guidelines to complex cases

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Priority Focus Areas from the Survey

1. Standardizing criteria for SRS/SRT (e.g., use/timing of MRI, immobilization, dose metrics, treatment imaging, etc.)
2. Neurocognitive preservation (e.g., hippocampal-sparing WBRT, greater use of memantine)

High variability, high impact, high interest

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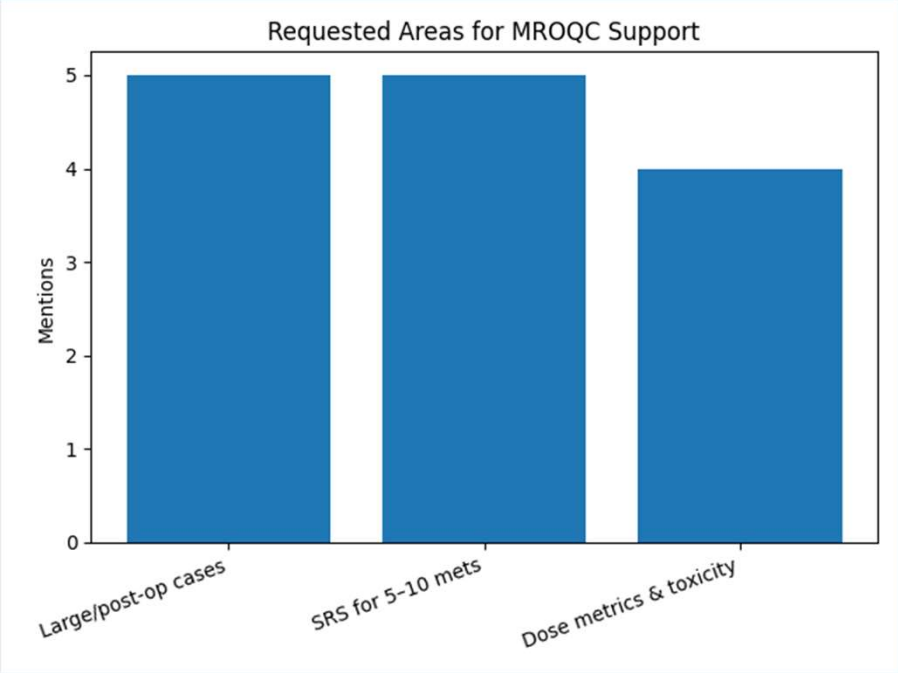
What Respondents Asked MROQC For

- Help with management of large and/or post-operative cases
- Techniques for SRS treatment of 5–10 metastases
- Refinement of dose metrics for meaningful toxicity



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Discussion: Large & Post-Op Cases

WHAT DRIVES DECISION-MAKING MOST?

WHERE DO MRI TIMING OR INPATIENT LOGISTICS INTERFERE?

WHAT TOOLS WOULD HELP MOST?

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Discussion: SRS for 5–10 Metastases

What tips the balance between SRS, SRT, and WBRT?

How much does machine capability matter?

Would shared planning examples help?

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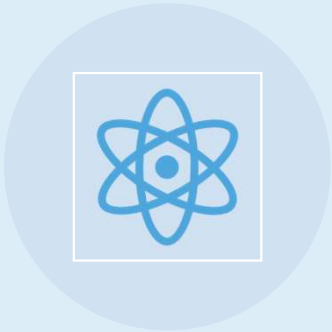
Discussion: Dose Metrics & Toxicity



WHICH DOSE METRICS TRULY GUIDE YOUR PRACTICE?

WHERE DO CONSTRAINTS FEEL UNCLEAR OR CONFLICTING?

WOULD CONSENSUS RANGES BE USEFUL?

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Proposed Next Steps

01

Focused subcommittees for each priority area

02

Start with education and consensus-building

03

Develop case-based resources and planning references

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Bone Metastases: Where MROQC Goes Next

As MROQC expands into Brain Metastases, Bone Mets remains an active QI priority

Near-term focus areas:

- **Re-irradiation**
  - Common in practice, limited standardization
  - Uncertainty around cumulative dose, toxicity, and patient selection
  - Area where MROQC has only begun to engage
- **Simulation-Free (SIM-Free) Radiation**
  - Growing interest for urgent and palliative scenarios
  - Potential to reduce treatment delays and patient burden
  - Variable workflows and readiness across facilities
- **Defining the next phase of Bone Mets QI**
  - Beyond initial dose/fractionation decisions
  - Emphasis on longitudinal care, retreatment, and evolving technology use
  - Opportunity for alignment where evidence is still emerging

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MROQC Mets Working Group Roadmap

Brain & Bone Metastases

🧠 Brain Metastases: Initial Focus

- Large and post-operative cases
- SRS techniques for 5–10 metastases
- Dose metrics tied to meaningful toxicity
- Emphasis on complex decision-making and system constraints(e.g., MRI access, re-irradiation considerations)

🦴 Bone Metastases: Next Phase of QI

- Re-irradiation
  - Patient selection, cumulative dose, toxicity
- Simulation-Free (SIM-Free) Radiation
  - Urgent and palliative workflows
- Moving beyond initial dose/fractionation toward longitudinal care

🔗 Shared Principles Across Brain & Bone Mets

- Education and consensus-building before measures
- Case-based learning and practical guidance
- Alignment where evidence and technology are evolving

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MROQC Mets Working Group: 2-Year Roadmap

2026: Focus & Foundation

Brain Metastases

- 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

- Develop consensus guidance and reference materials
- Identify opportunities for standardization *where appropriate*

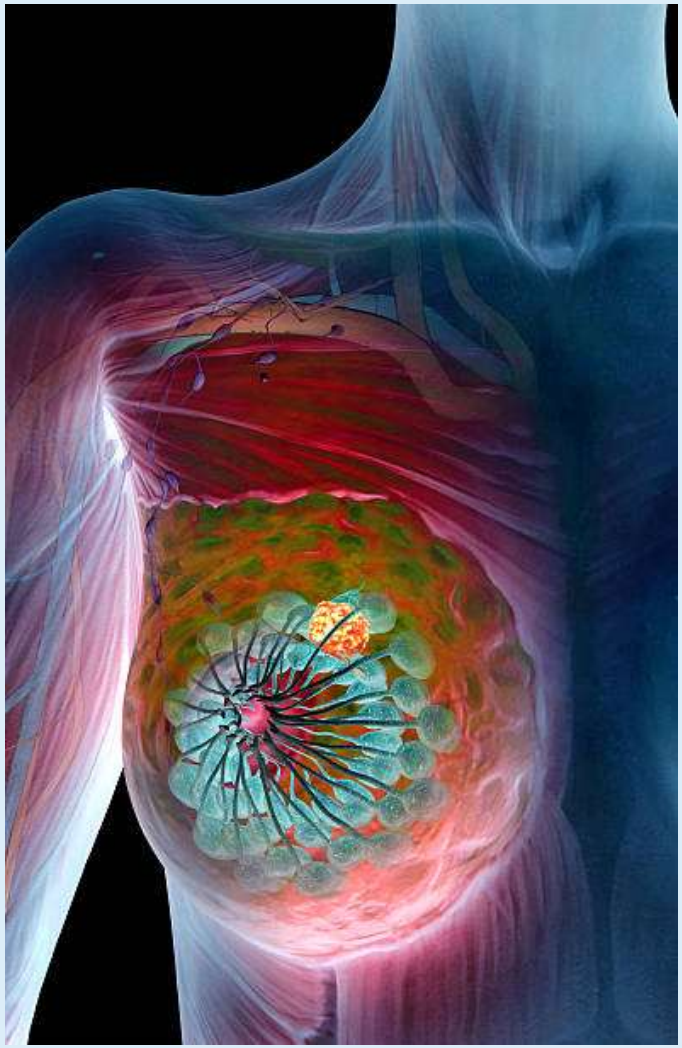
Bone Metastases

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

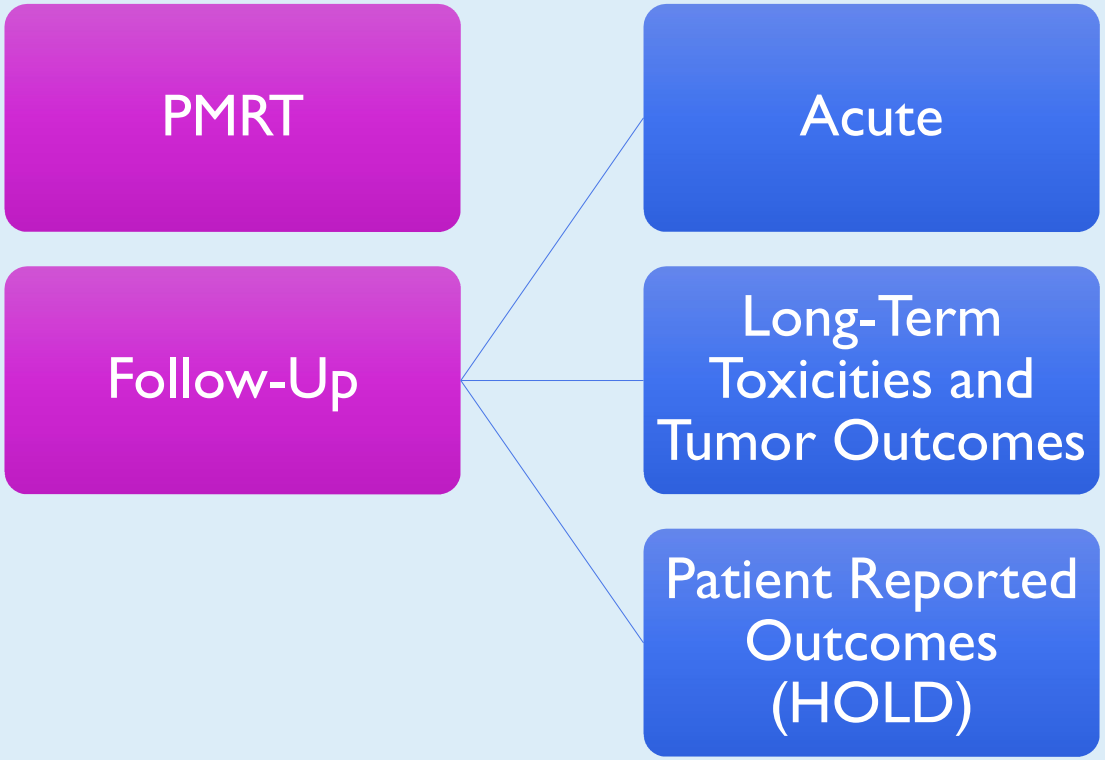
Start with shared understanding-build toward alignment.

MROQC Quality Improvement Breast Working Group Future Directions

Drs. Lori Pierce and Frank Vicini



Items to Cover Today:



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Post-Mastectomy Radiation Therapy-UPDATE

ARTICLE IN PRESS

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

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www.practicalradonc.org

Clinical Practice Guideline

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

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A Post-Mastectomy Radiation Therapy (PMRT) Committee has now been formed: Mike Dominello, Mazen Mislmani, Shelley Tibbs, Terri Bott-Kothari, Mark Zaki, Lori, Frank, Kent, Robin, and members of the Coordinating Center Core Team

First Meeting was held January 30th

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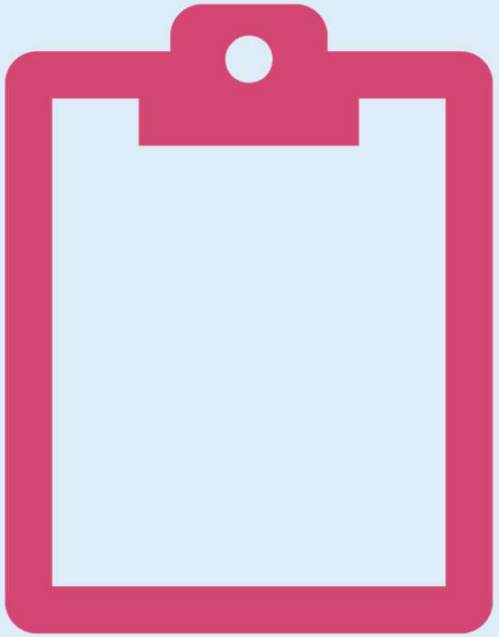
Post-Mastectomy Radiation Therapy: Next Steps

Their next step will be distributing a brief survey to assess PMRT practice patterns across MROQC breast physicians.



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Follow-Up and Outcomes: Discussion

During today's meeting, we would like to gauge additional interest in expanding our breast dataset to include follow-up and tumor outcome information. This would support long-term quality goals and allow us to understand outcomes more comprehensively across the patient journey.

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To Discuss: Breast Follow-Up and Outcomes

Acute Toxicities

- Is our current post-RT follow-up timeline appropriate with the newer shortened courses of treatment?

Long-Term Follow-Up

- Capturing disease status (toxicity and tumor outcomes) on patients already enrolled in MROQC at marked intervals (1, 3, 5 years) via chart abstraction

Patient Reported Outcomes (HOLD)

- From patients already enrolled in MROQC, gather patient reported outcomes (PROs) at advanced follow-up timepoints

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LTFU and Outcomes Poll

1. Do you support piloting expanded breast long-term follow-up and tumor outcome data collection within MROQC?
2. How feasible would participation in a pilot be at your facility?
3. Which follow-up timepoints should be considered for a pilot?
4. What is the single biggest concern for your facility regarding participation in a pilot?

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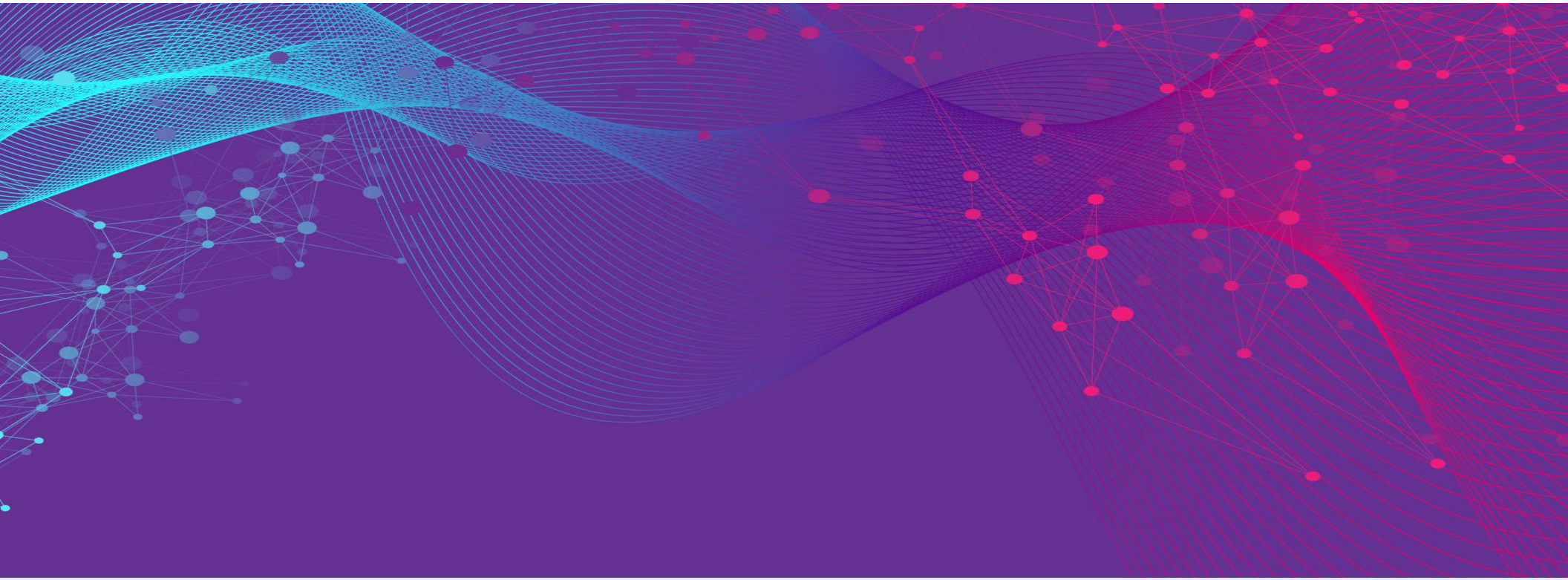

Q & A

Q & A

The floor is now open for discussion