

QOPI, EHRs, and Quality Measures

We read with great interest the article by Neuss et al (“A Process for Measuring the Quality of Cancer Care: The Quality Oncology Practice Initiative”) in the September 1, 2005, *Journal of Clinical Oncology*, and the Quality Oncology Practice Initiative (QOPI) article from the January 2006 *JOP*. From the perspectives of an electronic health record (EHR) vendor and a practicing oncologist, we found the reports on the QOPI system timely and laudable, and the results are encouraging. That the indicators largely improved between the two survey rounds was encouraging, especially given that the project is in its infancy. What was disheartening, however, was that the capability for collecting quality indicators using EHR systems was entertained neither in the conception of the study nor in the associated article discussions. While this is understandable given the limited penetration of EHR systems, it neglects considerations for scaling and evolving the QOPI program. Oncology-specific EHR systems are currently available and are capable of providing a robust infrastructure for support of quality-improvement projects. These systems will likely render manual data abstraction and collection methods obsolete, and help reduce the \$1,000 per-practice cost for the QOPI assessment—a cost that increases dramatically when applied to a nationwide system. Furthermore, the use of EHR systems in oncology will undoubtedly increase over time, and their costs can be offset by their potential for promoting efficiency, reducing medical errors, and enhancing quality care. Initiatives launched by the Office of the National Coordinator for Health Information Technology, the promotion of the Oncology Demonstration Programs by Centers for Medicare and Medicaid Services, and proposed legislation encouraging Pay for Performance, as well as patient demands, all suggest that widespread adoption of EHR systems by oncologists is imminent.

Advantages of embedding quality measures into the core of an EHR system abound. Indicators can be “calculated” based on data entered during the course of routine care, and reports of quality could become routine. Quality for all patients, not just a random few, could be tracked and quantified in real time. Using EHR systems, aggregation across practices along with centralized collection, comparison, and analysis is more readily supported. The same may be true for methods of abstracting, reviewing, auditing, and identifying other leading

and lagging quality indicators. By promoting and standardizing QOPI measures, data from disparate EHR systems could be compared, and otherwise leveraged in support of quality management. *Perhaps most importantly, an EHR can help promote the very quality it is responsible for measuring, by enforcing rules such as “no chemotherapy administration unless a consent is present.”*

We believe that quantification of most of the 11 QOPI indicators is already possible using commercially available oncology-specific EHR systems. However, as the QOPI project evolves, the following EHR-specific criteria would add significantly to the “ideal and practical” criteria introduced by the authors:

- Coordination and standardization of indicators among all the stakeholders, including professional societies, insurers, payers, patient advocacy groups, governmental organizations, accreditation bodies, and the practices themselves
- Consideration for ease of “calculating” the indicator from measures already present in an EHR. For example, whether an explicit statement of the patient’s staging has been entered is far easier to “calculate” and validate than whether there was appropriate use of chemotherapy and hormonal therapy for a subset of breast cancer patients

It is vital that all stakeholders agree upon a standardized nomenclature, lest the field degenerate into a “Tower of Babel.”

We agree with the authors that a process for gathering data concerning the quality of oncology care in individual practices needs to be expeditiously designed and implemented. The QOPI system may indeed allow rapid feedback of performance data for each of the selected indicators, but probably not as efficiently and rapidly as a QOPI-equipped EHR system. In an era where EHRs are coming of age, the time to incorporate indicators into the core of such systems is now. EHR vendors have an interest in collaborating in the development and adaptation of current indicators, but the responsibility of equipping EHRs to measure, track, and enhance quality in the oncology practice belongs to all of us.

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References

1. Neuss, M, Desch C, McNiff K, et al: A process for measuring quality of cancer care: The Quality Oncology Practice Initiative. *J Clin Oncol* 23:1-6, 2005

2. McNiff K: The Quality Oncology Practice Initiative. *J Oncol Pract* 2:26-29, 2006

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In the July 2006 *Journal of Oncology Practice*, page 167 of the Cover Story incorrectly used “ECGs” in place of the correct term, “echocardiograms.” The sentence should read as follows:

“They must also get in the habit of watching, and documenting, newer measures of potential toxicity, such as regular echocardiograms for patients on herceptin, and creatinines for those on zoledronic acid.”