QOPI, EHRs, and Quality Measurement

To the Editor: It was with great interest from the perspectives of an electronic health record (EHR) vendor and a practicing oncologist that we read the article by Neuss et al entitled: "A Process for Measuring the Quality of Cancer Care: The Quality Oncology Practice Initiative" in the September 1, 2007, issue of the *Journal of Clinical Oncology*¹ and the Quality Oncology Practice Initiative (QOPI) article in the January, 2006, issue of the *Journal of Oncology Practice*.² The reports on the QOPI system are 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 neither entertained 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 such 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 scales dramatically when one considers a nationwide system. Further, the market penetration and use of EHR systems in oncology will undoubtedly increase over time, with their costs offset by their proclivity for promoting efficiency, reducing medical errors, and enhancing quality care. Incentives launched by the Office of the National Coordinator for Health Information Technology, the promotion of the Oncology Demonstration Programs by the Centers for Medicare and Medicaid Services, and proposed legislation to incentivize pay for performance, as well as potential 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 in 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 as may be methods for 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 tasked with 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, and could be readily assessed within the context of a well-designed and implemented work flow process. 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 hormone therapy for a subset of patients with breast cancer.

Ultimately, all of the structural and process-related elements inherent in oncologic practice need to be examined to uncover, understand, optimize, and be correlated with treatment quality and efficacy. The material captured in the EHR and extracted from it likewise must be exportable in a standardized format that is clear, extensible, and fully documented. It is vital that all stakeholders agree on 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.

Joel W. Goldwein, MD
IMPAC Medical Systems Inc, Sunnyvale, CA

Christopher M. Rose, MD
Vantage Oncology, El Segundo, CA

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References

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