Ontario Health
Cancer Care Ontario

RT-QBP Frequently Asked Questions

Updated on October 20th, 2022

A. Clinical

1. **Question:** If the completed treatment is off by several Gy, should a listed protocol within the Databook file still be selected?

   Answer: Yes, there is a wide range for our dose fractionation schemes such that multiple treatment types can comfortably accommodate. For instance, there are numerous disease sites with short course or "Other" protocols (e.g., GI short course). A new protocol submission is not necessary. This could also pertain to situations where the treatment is not completed but could still fit under the dose/fractionation. In the future, a retrospective analysis will be done around commonly used protocols to inform the list.

2. **Question:** Who should be selecting the protocol? How is treatment intent determined? What is an example of this?

   Answer: Protocols were developed by expert panels of Radiation Oncologists for each disease site, representing centres across the province. As such, the protocol should be selected by the treating Radiation Oncologist once a decision to treat has been made. Please note that the intent of the treatment needs to be determined by the treating Radiation Oncologist and cannot be automatically linked to the intent of the RT protocol. The concept of "intent" has now morphed into which component of the cancer is being treated; the primary tumour (which includes regional nodes), or a metastasis. In some tumour types (e.g., lymphoma), it can be difficult to assess which is which, in which case we suggest that a primary site be selected. If you feel a protocol is missing, then a request for a new and/or modified protocol should be submitted (as appropriate). Please note that a few RT protocols are applicable to both primary and metastatic intents. For example:

   - A metastatic Stage IV lung patient is simultaneously getting treated with 20/5 to the original lung tumour and 20/5 to a bone met in the pelvis. In this case, the lung tumour (LUNG_SHORT_3) would be primary and the bone met (BONE_MET_SBRT_NONSPINE) would be metastatic. Two separate protocols would be submitted.
   - Another example is in metastatic prostate cancer, where the prostate is irradiated for local control (GU_SHORT_COURSE). In this case, the submitted protocol should be coded as primary.

3. **Question:** Can any specific clinical trial (CT) be added to the Databook list, given that it has a radiation arm?

   Answer: Similar to Systemic and Surgery QBPs, operational funding is not meant to cover experimental treatments. In clinical trials where radiation is part of the trial but is delivered in a manner consistent with standard of care, then centres should simply choose the protocol that would normally be chosen for that patient.

Trials on the CT list within Databook are those deemed to have the primary intervention as RT and are submitted/tracked by submission of their NCT# . A new clinical trial which fits the criteria should be investigating novel dose/fractionation, or technique.

In this situation, where the radiation is felt to be the novel agent under study, the RTP team at OH-CCO would work with the submitting centre to find a clinical protocol that aligns with the standard of care, i.e., how the patient would have been treated with radiation if there were not on this study.

4. **Question:** Can I treat a patient off trial with a Clinical Trial dose/fractionation?

   Answer: No, the trial dose/fractionation is not evidence-based and only patients registered on the trial can be submitted as a clinical trial patient.

5. **Question:** What is the purpose of short courses? When should they be used?

   Answer: There are several short courses across many disease sites. These short courses were devised by the radiation oncologists on the expert panels given that there are several clinical situations where the primary tumour requires palliation with a short course of radiotherapy.

6. **Question:** If a patient has a local recurrence after initial treatment, would this be considered as the same primary?

   Answer: If recurrence is local, then it is considered primary.

7. **Question:** Are there any RT protocol for unspecified metastatic disease?

   Answer: Yes. In general, all metastatic cases can be covered under “ANY” in the "RT_CLINICAL_PRTC_GRP" and "RT_CLINICAL_PRTC_SUB_GRP" columns. Protocols include the following: UNSPEC_MET_MULT_FRAC, UNSPEC_MET_SINGLE, UNSPECIFIED_MET_SBRT.

8. **Question:** Should re-planning activities be submitted?

   Answer: All activities must be submitted into Databook, including re-planning activities. If a patient is re-planned and a new course is created, the same RTT date and Protocol name must be selected.

   The potential for re-planning has ALREADY been factored into the micro-costing of the Primary protocols for Head and Neck and Lung disease sites.

9. **Question:** Is dosing required on a fraction to be counted as a fraction. If dose is missing, is this considered non-evidence informed and not funded?

   Answer: Yes, dosing is required on a fraction. If dose is missing, the submitted protocol will be funded but these protocols will be flagged as non-compliant when looking into dose and fractionation.

10. **Question:** Which variables are used to count fractions in the ALR data?
    Answer: Treatment type NHPIP codes.

11. **Question:** For all operational reports involving PHI information, can disease site number and CR number be provided in all the reports?

Answer: The PHI level reports include disease number and registration date as well as MRN and HIN.

12. **Question:** How to handle the treatment protocol for an unknown primary diagnosis?

    Example: Patient has an unknown primary diagnosis but attending physician suggested the diagnosis will be likely Ca thyroid case. What RT Protocol should be used? ENDO(HN)001?

    Answer: If the physician has determined that the patient has Thyroid Cancer, the diagnosis submitted should reflect that using ICDO3 Topography and Morphology. We currently have two protocols for Thyroid Cancer: 1) ENDO_THYROID and 2) ENDO_THYROID_NONDIFF_HYPER

13. **Question:** Have the best practice care pathways been shared?

    Answer: The standard of care protocols were developed by clinical expert panels and larger disease specific working groups. These protocols are available on the Databook website and in the Clinical Handbook area along with Quality Expectations.

14. **Question:** How do the quality metrics factor into the QBP?

    Answer: In regard to Quality Expectations, the clinical experts and working groups developed nearly 700 QEs. Current work is focused on identifying the QEs that can be prioritized for the next year. The QMs are not meant to be punitive where funding is impacted if they are not adhered to, but rather, there is work being done on adding on quality aspects on top of the current protocols. For example, the following are two examples of quality metrics for breast cancer treatment:

    - Recommended: “Contouring of appropriate lymph nodes is recommended, especially in cases with locally advanced disease.”
    - Essential/Must: “The heart should be contoured on the treatment planning computed tomography scan in accordance with Radiation Therapy Oncology Group guidelines.”

15. **Question:** What is the correct way to update cases where the prior intent was curative, particularly when the prior intent followed the pre-QBP format?

    Answer: In the scenario of a case being previously reported with either curative, adjuvant or neo-adjuvant treatment intent, the previous treatment will be treated the same as primary and would trigger the reconsult bundle if the patient proceeds to metastatic treatment.

B. Funding Triggers

Please note that RT-QBP Funding guide report provides detailed information on funding rates triggers, and scenarios.

1. **Question:** If a patient does not finish the prescribed protocol, will they still get funded?

   Answer: We would expect that some patients would not complete the prescribed treatment for medical or other reasons, but this would be fully funded. Please ensure that the course of treatment is flagged as completed for Databook submission. We will also be tracking the percentage of protocols that are outside of the dose/fractionation range.

2. **Question:** If an in-patient is seen for a new consult, will this activity still trigger funding?

   Answer: This triggers a Consult Bundle (C1R) and is paid at the appropriate rate.

3. **Question:** How does the bundle trigger work if a patient starts on a treatment protocol, completes only part of the protocol, and then comes back to the same protocol months later?

   Example: Duputren's disease (RT Protocol - NONNEO(SAC)002). The Patient will receive 15 Gy in 5 fractions and then take a 4-8 week break before having another 15 Gy in 5 fractions (Total dose = 30 Gy in 10 fractions). In some scenarios, unanticipated delays for the second half of the treatment were experienced.

   Answer: In the case above, the second part of the treatment should be submitted with the same Ready to Treat (RTT) date so that two phases could be linked and trigger a single treatment bundle upon completion.

4. **Question:** How does the bundle trigger work if a patient gets the same protocol consecutively in a short amount of time (with little downtime in between)? What happens if a patient does not finish the first protocol treatment and restart?

   Example: Palliative SBRT spine treated (T4-5) with a dose fractionation of 24 Gy in 2 fractions (RT Protocol - ANY007) in April and then another SBRT spine treated (T12) with same dose fractionation planned in end of May and treated in early June.

   Answer: The treatment bundle will be triggered once the first (T4-5 spine) protocol is completed. If the second treatment to T12 is done using the initial CT Sim, these two courses will be merged into 1 SBRT spine protocol instance. If a new CT Sim is done for the second treatment, it will be paid as a second protocol instance once completed.

   Funding will be triggered once the first protocol is competed regardless on delay. OH-CCO will only force complete a course after 60 days of inactivity.

5. **Question:** What is the funding trigger and frequency for Infrastructure bundle? Are CT-SIM and MR-SIM included in Infrastructure bundle funding?

Answer: Unlike the volume-based bundle, the Infrastructure bundle does not have a trigger. The annual payment for this bundle is based on the hospital's current inventory of high energy treatment machines and brachytherapy units. Although the count of high energy treatment units would not include equipment such as CT-SIM, MR-SIM, Orthovoltage units, and other major and minor equipment, their costs are included in the price of the Infrastructure bundle.

6. **Question:** Is funding only for fully completed protocols?

   Answer: Funding will be provided for protocols where some radiation was delivered. We also understand that in some cases, the full dose may not be delivered due to disease progression or other medical reasons.

7. **Question:** How can the centres submit "rectal spacer inserted" for specific patients?

   Answer: For identifying that a Rectal Spacer was used for a specific protocol instance, at least one of the courses of treatment representing this protocol instance must contain a Rectal Spacer activity having *NHPIP_ACT_CD* = 399 (*NHPIP_ACT_DESC* = Insertion of rectal spacer).

8. **Question:** If multiple sites are being treated on a patient and the two areas are combined into a single treatment plan (e.g., t-spine and central lung lesion at the same level), how should this be submitted? One example is when a patient with a lung primary has their tumour treated simultaneously as their T5 bone met.

   Answer: In this case, it would be most appropriate to submit the protocol that has the highest workload.

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C. Costing

Please note that the RT-QBP Costing report describes in detail the process and methodology to estimate costs for various components of funding bundles.

1. **Question:** Why are purchase costs for generic major equipment (e.g., anesthesia machines, cardiac defibrillators) excluded?

   Answer: Purchase costs of equipment not specific to radiation treatment, such as anesthesia machines and cardiac defibrillators, is out of scope for RT-QBP funding.

2. **Question:** Is there an incentive for the centres to move towards submitting the most expensive protocols?

   Answer: No. Protocols that are grouped in higher price-bands or have high un-banded price points, are all associated with higher costs to the hospitals (e.g., supplies, workload/number of treatments), and as such, represent flow-through costs with no profit margin. The selection of a treatment protocol should be based on its clinical appropriateness for patient being treated and not the band price.

3. **Question:** How are centre-specific cost drivers recognized by the model? Examples are: program size, impact of geographical (e.g., Northern) location, programs with specialized equipment involving higher SSA costs (e.g., MR-Sim, Gamma Knife, Cyberknife, etc.), programs operating a 24/7 model of care resulting in higher replacement/parts costs?

   Answer: A targeted analysis was conducted to compare the impact of all aforementioned factors on infrastructure cost per facility. It was found that in vast majority of cases, these factors balance off across facilities, and the funding approach proposed in the final model (two rates per LINAC and one brachytherapy rate) is optimal for Infrastructure bundle.

4. **Question:** Will the funding for new LINACs be prorated and what is the funding trigger for new LINACs?

   Answer: The funding for new LINACs will be prorated and currently, the trigger is to be determined. We will communicate this information as soon as it is available.

5. **Question:** How is re-planning taken into account in terms of cost?

   Answer: Based on RT-QBP clinical leadership recommendation, the following re-planning rates are embedded in costing: All lung protocols at 5% (i.e., 5% of planning activity increased), all Head and Neck protocols at 10%. Re-planning rates apply to the simulation (CT and if applicable MRI) and treatment planning phases.

6. **Question:** How were the costs of CSRTs incorporated into the RT-QBP?

Answer: Specific activities were not broken down by RT or CSRT as the focus was on activities required for patients, not the staff type. The hourly rate used for costing was adjusted based on the weighted average of MRT and CSRT salaries from each centre, using FTE.