Origins of the Quality Oncology Practice Initiative

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The impetus for founding the Quality Oncology Practice Initiative (QOPI) arose from the convergence of three experiences. First, I am a pediatric oncologist. The practice model of pediatric oncology differs greatly from that of most adult cancer therapy in several respects: Concurrent multidisciplinary care is routinely provided; a physician navigator provides longitudinal medical direction for the patient and family; most patients participate in clinical trials that require prior peer-reviewed planning of therapy and a structured review of outcomes; and because most pediatric oncologists are employed at children's hospitals or cancer centers, fees for technology, procedures, chemotherapy, and laboratory work are retained by the institutions, removing potential conflicts of interest from medical recommendations. I believe this is a superior model of cancer care because it inherently promotes quality care.

Second, I served on the National Cancer Policy Board of the Institute of Medicine (IOM) from 1996 to 2005. The major work of the board was to issue rigorously peer-reviewed reports that included recommendations with the potential to aid or influence policy makers. Several of those reports concerned the quality of cancer care, such as *Ensuring Quality Cancer Care*[1] in 1999 and *Enhancing Data Systems to Improve the Quality of Cancer Care*[2] in 2000. Participation in this series of analyses provided an understanding of the robust literature describing the wide variability of the quality of cancer care in the United States.

Third, during my term at the IOM, the Bush administration was preparing legislation that would ultimately be passed by Congress on December 8, 2003, as the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[3] In the 2 years preceding passage of the bill, the medical oncology community was in an uproar. Because Medicare funds exist in two separate categories (ie, prescription drugs and everything else), in order to provide a costly additional pharmaceutical benefit to seniors, the money had to come out of the prescription drug pot. Because many of the most expensive drugs were prescribed by oncologists, Congress planned to change the formula for reimbursing oncologists and other medical specialists for the purchase, resale, and administration of drugs to patients, which would have reduced physicians' income. ASCO was heavily involved in the attempt to modify the bill, which involved many trips to Capitol Hill. These activities consumed a great deal of ASCO's energy, leading some members to reflect on the propriety of these efforts and to fear that ASCO was becoming known more for its interest in personal income than in patient care and education. Others asked, "Where is the patient in all of this?"

In response to these concerns as well as to the IOM reports, ASCO formed the Quality Working Group, of which I was a member. The group grappled with what to do, but it was unable to shape a viable quality plan. After much whining and agitation on my part, ASCO asked me to develop a proposal to be presented to the ASCO Board of Directors at its November 2002 meeting. I formed a steering committee that included Peter Eisenberg, MD, Monica Morrow, MD, Thomas Smith, MD, Philip Stella, MD, Ellen Stovall, Rodger Winn, MD, Robert Young, MD, and George Browman, MD. On September 10, 2002, we sent the board a draft proposal, which included the background, rationale, and specific characteristics of a new approach. The vision of the initiative was and is: ASCO becomes the international leader in promoting high-quality cancer care. The mission: to develop and promote a practical program for promoting excellence in cancer care that first, can be used anywhere; second, measures progress; and third, rewards successful participants in the program. The final version was delivered to the board in November 2002, and after some hesitancy, the board approved the initial effort. The bedrock principles we established were that this voluntary program and its data would be run and managed by the participating physicians; de-identified data would be collected by practices and submitted to ASCO for data management; the results would be returned to participating practices, showing their performance compared with other practices; no money would be taken from the pharmaceutical industry; and ASCO would provide some support, but most of the work would be done by volunteers.

In early 2003, I approached friends about medical oncology practices interested in quality-of-care issues to test the model. I initially asked seven practices to participate, and they all accepted. The practice champions in this alpha group were Peter Eisenberg, MD, Christopher Desch, MD, Dean Gesme, MD, Mike Neuss, MD, Mohammad Jahanzeb, MD, Joseph Jacobson, MD, and John Rainey, MD. After trial runs, a beta group was enlisted that included Albert Casazza, MD, Kevin Knopf, MD, Denis Hammond, MD, Russell Hoverman, MD, PhD, John Keech, DO, Richard McGee, MD, Therese Mulvey, MD, and Judy Schmidt, MD. This was followed by the gamma group, the third and final pilot group, which included Richard Levine, MD, Jacob Frick, MD, Gilberto Rodrigues, MD, Bohdan Halibey, MD, Roscoe Morton, MD, Barbara McAneny, MD, Kent Adler, MD, and John Cox, DO.

These 25 practices composing the three pilot groups, along with Kristen McNiff, MPH, at ASCO, did all the spade work in preparing QOPI to be opened to any ASCO member in 2006. QOPI now has 500 participating practices that report data on approximately 35,000 medical records annually. Kudos to all participants for making QOPI a force in promoting quality cancer care.

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Quality Oncology Practice Initiative Certification Program: Overview, Measure Scoring Methodology, and Site Assessment Standards

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The concepts of quality assessment, monitoring, improvement, and accountability are becoming mainstream in US medicine. Pressure to demonstrate high-quality care and a commitment to continuous quality improvement are mounting for health care providers. For a time, quality efforts focused on areas outside of cancer care, most notably on primary care, cardiology, and diabetes care. This is likely a reflection of the complexity of cancer care, the limitations of claims data in providing meaningful quality analyses, and the emotional context of cancer rather than of the confidence that all cancer care is appropriate and safe.

Background

More than a decade ago, the Institute of Medicine increased the focus on oncology with the creation of the National Cancer Policy Board. Its final report, *Ensuring Quality Cancer Care*, identified a need to create systems to assess the quality of cancer care nationally.[1] This seminal publication generated a cascade of quality reports, initiatives, and projects in the years afterward, including the ASCO Quality Oncology Practice Initiative (QOPI).

Joseph Simone, MD, chair of the National Cancer Policy Board, put forth the initial concept for QOPI. In 2002, he recruited a small group of medical oncologists to develop and pilot a voluntary program to assess and improve processes of care in oncology practices.[2] QOPI was made available to all ASCO-member medical oncologists and their practices in 2006.

QOPI provides a system for practices to measure processes of care semiannually, using retrospective medical record abstraction methodology. Practice personnel select patients who meet QOPI sampling requirements, starting with the most recent patients seen in practice and proceeding backward in time for up to 6 months to meet the sample size. The number of full-time equivalent medical oncologists or hematologist-oncologists at a practice site determines the QOPI abstraction sample size. The QOPI patient selection methodology and sample size have been previously described.[3] A practice submits a limited data set to the QOPI database using a structured, secure online patient report form, and results are analyzed and reported back to the practice.

The analyzed QOPI quality reports are the primary benefit of QOPI participation. Reports are available within 4 weeks of the close of data collection, so practices can use data received for targeted improvement. For each quality measure, reports detail practice-specific data (and office-specific data, if collected at multiple sites) and comparative aggregate data.

The QOPI measures are organized into a required core set and disease- and domain-specific modules. The core measures are