From the Editor's Desk

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"I Know It When I See It"

Quality is a complicated concept. Quality implies a premium, a distinctive service or product, or something of high value in our lives, such as quality time. One cannot imagine something of value that does not have quality as an attribute. Defining quality in health care has vexed many. As with other hard-to-define concepts, the paraphrased statement by Supreme Court Justice Potter Stewart concerning pornography—"I know it when I see it"—is often applied. However, relying on such an intuitive standard regarding what constitutes quality care should make us uneasy. Some try to objectify quality in health care by incorporating it into an economic expression: value = quality/cost; thus, quality is moderated by the context of the care, including the perception of the patient. Others ignore any context and define quality in terms of adherence to evidence, relegating the definition to only those parameters defined by empirical clinical study for which there are metrics.

The genius of the Quality Oncology Practice Initiative (QOPI) is that it recognizes that quality in oncology care must rely on all of these realms. Some of the QOPI assessments are intuitive, "smell tests," if you will. One example is the awareness that it is difficult to provide good care to patients without a simple organizational flow sheet and good record keeping. Because we are an evidence-based science, specific measures to assess whether appropriate therapy is provided to the right patient at the right time is a core assessment of quality. Lastly, one has to have an appropriate context of care. This realm is served by the certification and reporting programs outlined in this issue of *Journal of Oncology Practice*. Adhering to principles that define the structure of our delivery of care and allowing payers to judge our performance force assessment of costs and of patient and team satisfaction. Associate editor Joe Jacobson, MD, has organized a presentation of QOPI that reflects on its history and introduces its future directions.

We at ASCO are proud of the success of QOPI. Education is a (the!) core value of ASCO. At heart, QOPI provides structure for oncologists to assess themselves, allowing us to reflect on how to provide better care for our patients and, in essence, measuring the results of our education. A distinctive aspect of QOPI is that it is designed by members of ASCO so we can hold ourselves accountable. Many bemoan the activities of our profession that are no longer in our sphere of control. With the advent of the QOPI Certification Program, our profession strengthens its loud and authoritative voice in defining oncology quality. Congratulations to the authors of this special series, to the leadership of QOPI, and to the practices that mold the program annually (and to the original vision of Joe Simone, MD). QOPI is an expression of the best of ASCO.

Deserving of the additional emphasis and attention of readers are the measures of safe oncology practice outlined in the feature article. ASCO and the Oncology Nursing Society collaborated in outlining principles of chemotherapy and practice safety. The details and background of these measures have been published in *Journal of Clinical Oncology*.¹ Readers are encouraged to review the *JCO* publication and online supplemental materials provided at <http://qopi.asco.org>. Even if one chooses not to participate in the QOPI Certification process, every oncology practice (out patient or in patient, private or academic) should be aware of these principles.

Two original reports are presented in this issue of *JOP*. Bretzel et al highlight the need to be aware of and assess dose intensity in adjuvant treatment of breast cancer. Their suggestions fit well in this issue, which reflects on quality of care delivery. Figg et al speak to the business of oncology practice. Oncologists recognize the import of monitoring a practice's payer mix of privately insured patients relative to patients covered by government programs. The higher reimbursement of private insurers offsets the borderline reimbursement of Medicare/Medicaid. The authors remind us of the converse of this balance. Private insurers pay us better, but it costs significantly more in practice resources to manage their demands compared with government payers, which adds another wrinkle in managing the precarious balance of revenue and cost, underlined by Towle et al² in the last issue of *JOP*.

Good reading, and as always, the editorial staff welcomes feedback and suggestions at jopeditorsdesk@asco.org.

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References

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2. Towle EL, Barr TR: 2009 National Practice Benchmark: Report on 2008 data. *J Oncol Pract* 5:223-227, 2009