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Development and Future of the American Society of Clinical Oncology's Quality Oncology Practice Initiative

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Origins and Development of the Quality Oncology Practice Initiative

The Quality Oncology Practice Initiative (QOPI) has been a driving factor in cancer care quality for more than a decade. QOPI's launch marked a significant moment in the history of the American Society of Clinical Oncology (ASCO), and its success reflects a remarkable willingness of oncologists to undergo self-examination and improvement and to do so in advance of external requirements.

The 1999 report of the National Cancer Policy Board. The path for QOPI was set in 1997 when the Institute of Medicine (IOM) created a National Cancer Policy Board to assess the state of cancer care within the United States. The board's report, issued in 1999,[1] concluded that many Americans with cancer do not receive the best evidence-based care, although there was insufficient information to truly assess quality. Among the report's 10 recommendations were recommendations to measure and monitor the quality of care using a core set of quality measures and develop a cancer data system that can provide quality benchmarks for use by hospitals, provider groups, and managed-care systems.

ASCO's national initiative on cancer care quality. The IOM report was a call-to-action for many in the oncology community; it set into motion a flurry of activity aimed at studying and improving the quality of cancer care. ASCO initiated a 5-year study, the National Initiative on Cancer Care Quality, to test a methodology to assess the care of people with breast and colorectal cancer treated within five geographic areas. This cross-sectional study revealed relatively high adherence to accepted standards of care but also demonstrated broad variation for some measures and room for improvement in key areas.[2] Moreover, it underscored the many challenges of implementing a cost-effective and efficient system for national quality monitoring. The National Initiative on Cancer Care Quality, and other initiatives and studies prompted by the IOM report, provided needed national data but limited insight into the quality of the care provided by oncologists and their teams in day-to-day settings.

The origin of ASCO's ongoing commitment to quality practice. To address this gap, Joseph Simone, a pediatric oncologist, active ASCO member, and chair of the National Cancer Policy Board, proposed an alternative approach to ASCO leadership. He outlined a quality assessment program with a national infrastructure but local implementation, with locally engaged leadership and with commitment from the medical oncology community. At that time, national reporting programs were largely limited to hospitals and medical centers and focused on surgical or other brief episodes of care (eg, related to 30-day surgical outcomes). By contrast, a medical oncology program would require implementation in ambulatory (and largely private or community-based) practice settings, where the vast majority of cancer care was provided.[3]

The QOPI alpha group. Simone suggested a bold vision—ASCO would become a leader for implementing a practice-level system for promoting excellence in cancer care. He proposed that ASCO develop and promote a program of excellence in cancer care that was relevant and valuable to all practices, was feasible to install anywhere, measured progress, rewarded successful participants, and supported ASCO's goals and mission. Simone presented a pilot plan for QOPI to ASCO's board of directors in November 2002. He personally selected the initial participating practices, which included members of ASCO's board of directors and health services committee, as well as representatives from community oncology practices. The first seven practices (the alpha group) each appointed a senior representative to participate in building the QOPI program.

The alpha group began meeting via conference call in January 2003, preparing a methodology for QOPI that balanced feasibility and rigor. QOPI was piloted as a retrospective medical records abstraction, based on a sampling strategy that preferentially included patients with an invasive malignancy most recently seen in clinic. The alpha group determined that data submission should occur at roughly 6-month intervals to allow for review of data reports and implementation of improvement strategies. The first pilot data collection period was

completed in May 2003. The seven practices submitted data from as many as 85 patients seen at each practice site in the 6 months prior to allow for calculation of 11 quality measures. Six months later, the process was repeated. The mean frequencies of compliance for each indicator were shared among participating practices.[4] Representative QOPI measures are shown in Table 1.

Beta and gamma expansion. The alpha group determined that QOPI was appropriately feasible and useful to justify invitation of an additional group (beta) of eight practices to participate in two rounds of data collection in 2004 and 2005. Finally, in 2005, a third group of eight practices (gamma) was invited to participate. In total, QOPI was piloted from 2003 to 2006. Refinements were made throughout the pilot until data collection and analysis functioned well and the measure set grew to 35 measures.

The QOPI experience was presented to ASCO's Health Services Committee and initial data and improvement stories were presented at ASCO's Annual Meeting. Other oncologists expressed interest in joining, which resulted in a waiting list of nearly 100 practices. Participation in QOPI was made available to the practice of any United States–based ASCO member in 2006.[5]

Table 1. Selected QOPI Measures

Measure No.	Module	Description
55	Disease: breast cancer	Trastuzumab recommended for patients with AJCC stage I (T1c) to III HER2/*neu*-positive breast cancer
56	Disease: breast cancer	Trastuzumab received when HER2/*neu* is negative or undocumented (lower score - better)
57	Certification (adjuvant group) Disease: breast cancer	Trastuzumab received by patients with AJCC stage I (T1c) to III HER2/*neu* positive breast cancer (opposite of measure 56)
51		Genetic testing addressed appropriately for patients with invasive breast cancer (defect-free measure, 51a-51c; test measure)
51a		Genetic counseling, referral for counseling, or genetic testing for patients with invasive breast cancer with increased hereditary risk of breast cancer (test measure)
51b		Patient consent for genetic testing ordered by the practice for patients with invasive breast cancer (test measure)
51c		Patient with invasive breast cancer counseled, or referred for counseling, to discuss results following genetic testing (test measure)
62c	Disease: breast cancer Test–top 5	Serum tumor marker surveillance within 12 mo after diagnosis of breast cancer in patients who received treatment with curative intent (lower score - better; test measure - top 5)
91	Disease: ovarian, fallopian tube, primary peritoneal	Complete staging for women with invasive stage I-IIIB ovarian, fallopian tube, or peritoneal cancer who have undergone cytoreduction (test measure)

Abbreviations: AJCC, American Joint Committee on Cancer; HER2, human epidermal growth factor receptor 2; QOPI, Quality Oncology Practice Initiative.

Development Lessons From the Field

The vision for QOPI was based on a fundamental assumption: that medical oncologists possess an innate interest in understanding and improving the quality of care they provide. However, there were no national quality monitoring programs for ambulatory care settings known to the QOPI developers. Why has QOPI achieved acceptance and growth in the medical oncology community? The authors attribute QOPI's success to multiple factors.

Bedrock principles. To promote acceptance among oncologists, several bedrock principles were established by Simone before the QOPI pilot launch:

The voluntary program would be run and managed by a committee of participating physicians.

Patient-level data would be collected by practices and submitted to ASCO for data management.

Results would be returned to the participating practices showing their performance compared with other (unidentified) practices.

ASCO would not charge practices for participating; the only cost for practices would be resources required for data abstraction.

The program would not accept industry support.

ASCO member volunteers would determine the content and implementation of the program, with support from ASCO staff.

These bedrock principles have been instrumental to QOPI's success and have continued to guide the evolution of the program.

Commitment of practices and physician champions. A building body of evidence demonstrates the importance of physician champions as well as sponsor and leadership buy-in for the success of quality programs, particularly in smaller ambulatory settings.[6] We found these to be critical to the development, acceptance, and expansion of the QOPI program.

First, QOPI benefited from the direction of Simone, who guided the initiative from a position as the most senior oncologist on the project. He inspired trust and confidence among the ASCO leadership and pilot participants. His association lent credibility to the program as it grew. In addition, from QOPI's outset, the pilot group was able to commit the time that was required to participate in development activities and oversee their own practices' participation. Each of the pilot group members were in sufficiently senior positions in their practices that they could ensure ongoing operational commitment. Importantly, the pilot physicians became spokespeople for the QOPI program among their colleagues and peers. Ultimately, QOPI grew as a grassroots program—one developed by oncologists, for oncologists.

Use time wisely. Simone insisted that good telephone meeting management be observed to efficiently use the volunteers' time. Standing, weekly conference calls were convened and limited to one hour. Face-to-face meetings were held only at the ASCO Annual Meeting. ASCO headquarters staff supported the volunteers with meeting preparation and identification of additional headquarters resources.

Start small and expand. The most common catchphrase for the QOPI pilot was, "Don't let the perfect be the enemy of the good." QOPI itself was operated through small tests of change, a model borrowed from quality improvement. Changes that were deemed

improvements and those that achieved the buy-in and support from participants were implemented for the full program. Even in QOPI's current state as a large, national program, it remains a test bed for pilot innovations.

Use an approach of comprehensive but nonpunitive data analysis. The alpha group undertook the initial QOPI measure development. They agreed that QOPI measures would not result in passing or failing scores; rather, reports would be designed to identify opportunities for improvement. One of the primary values of QOPI was seen as the ability of the program to provide national aggregate benchmark or comparison data, which was completely lacking in outpatient medical oncology. Further, the alpha group agreed that QOPI would not disclose an individual practice's result without the practice's permission, although practices would be permitted to share their own practice-specific reports with their payers if desired.

The focus on improvement rather than judgment has allowed QOPI-wide latitude to expand quality measures. Today, QOPI measures overuse and underuse as well as misuse of care. QOPI now serves as a measure laboratory, allowing ASCO to test the validity, data capture feasibility, and improvement utility of scores of measure concepts. National aggregate data enable meaningful integration of measures without a known ideal state (such as the rate of hospice referral). The safe and nonpunitive environment encourages exploration of topics for quality assessment that might otherwise seem overly investigative or threatening. Oncologists continue to retain control of the measures developed and selected for QOPI.

Provide a sustainable and robust infrastructure. At initiation, the challenges involved in launching a quality assessment program in small, outpatient medical oncology practices were daunting. The goal was to create a practical program for small oncology practices, rather than a program only within reach of large, hospital-based or highly resourced academic medical center–based practices and cancer centers. Because fully implemented electronic health records (EHRs) were few, the alpha group met oncologists where they were, and developed an abstraction system based on the classic, paper-based medical record. The initial QOPI infrastructure was designed to assess adherence to important patient care processes in a cross-sectional sampling of patients managed over the preceding 6 months. Practice personnel (who are experienced with the practice's medical record system, including office nurses, clinical trial data managers, or tumor registrars) are guided through the abstraction of patient charts and entry of a limited, deidentified data set into the Health Insurance Portability and Accountability Act (HIPAA)–compliant, ASCO-sponsored repository. Physicians are proscribed from abstracting charts on their own patients; in practice, physicians rarely abstract any data. Time required per chart abstraction was estimated at slightly more than one hour using disinterested (eg, not directly involved in patient care) personnel.[7] In addition, ASCO staff offered training and telephonic help desk support.

Do not underestimate the power of data. QOPI's most important contribution is relevant and targeted medical oncology data. The primary purpose of these data is for quality reporting to participating practices; however, thoughtful dissemination of aggregated QOPI data has been critical to demonstrating the program's value. During the pilot, presentations at ASCO Annual Meetings and summary publications generated interest in the program, and an appreciation for QOPI as a unique data source. We have been able to examine experiences with the project and publish a variety of papers describing QOPI's development and growth, analyses from QOPI data, and descriptions of derivative projects. Selected publications are reviewed in Table 2.

Where We Are Now

Measuring and improving quality of care is a core competency of ASCO. Since 2006, when QOPI was opened to participation by any US ASCO member, the numbers of participating practices, providers, and patient charts abstracted have continued to grow. Figure 1 illustrates QOPI's ongoing growth. Today, approximately 450 practices participate each year, representing nearly 4,000 oncologists throughout the United States. This is a remarkable rate of voluntary participation, and although QOPI is a free member benefit for US ASCO members, the participating practices must cover the costs of data abstraction. In addition, QOPI was successful in establishing quality as a core competency of ASCO and led to the theme of "Enhancing Quality Through Innovation"[18] as a presidential theme in 2010; to the QOPI certification program; and to the creation of CancerLinQ, a rapid-learning oncology system we describe later in this article.

The QOPI certification program. The most important programmatic expansion of QOPI to date has been the development of the QOPI certification program. Launched in 2010 in response to requests to raise the bar for quality assessment and to demonstrate to external parties (eg, in marketing and to payers) an indication of quality achieved appropriate for sharing externally.[14] The QOPI certification program provides a practice-level certification for oncologists that meet scoring requirements on QOPI measures and demonstrate compliance with safety standards.[15]

The challenge for ASCO in preparing the QOPI certification program was how to establish the requirements and thresholds of quality. Participation in QOPI measurement rounds was recognized as an important but insufficient achievement for practices. To be QOPI certified, a medical oncology practice is required to demonstrate proficiency in care delivery and evidence of patient safety practices. Demonstration of proficiency in care delivery means attaining high scores in five QOPI modules. Initially, evidence of patient safety meant compliance with seventeen of the ASCO/Oncology Nursing Society Standards for Safe Chemotherapy Administration[19]; in 2013, the number of safety standards was expanded to 20.

The initial step in applying for certification is submission of documentation. Source documents (ie, patient charts with identifiers removed) are checked against the QOPI database to ensure accurate data abstraction. Structured onsite audits, which also examine source documentation, policies and procedures, and adherence to stated policies, are conducted by advanced-degree oncology nurses. The audits were initially performed on randomly selected practices, but universal audits were begun in September 2011. In early experiences with the first 111 applicants to undergo onsite review, only two were fully concordant with all of the standards.[9] Most practices were subsequently able to modify their practices to become QOPI-certified. With QOPI certification, practices are only required to participate in one data abstraction round per year, which reduces the data abstraction time required as a partial reward for certification. At the time of this writing, 275 practices have applied to become QOPI certified, and 220 have succeeded; 82 have applied for recertification after their 3-year term. Certified practices represent more than 2,022 oncologists

Table 2. Selected QOPI Articles

Article	Description
Neuss et al 2013[8]	Five years of QOPI data from 156 practice groups who participated over 5 years and completed a mean of five rounds of data abstraction are presented. Mean quality scores improved; adherence to process measures of adjuvant therapy for breast, lung, and colorectal cancer was uniformly high at the first and subsequent measurements. Greater and faster improvement was seen in measures of newly introduced clinical information, but pain control and EOL management did not significantly change.
Gilmore et al 2013[9]	This is an in-depth review of the QOPI certification process, the QOPI certification standards that are assessed, and key observations from the first 3 years of the program. Of the first 119 practices undertaking the process, 92.8% required more work on at least one standard as identified during the onsite review. The article highlights standards most often failed.
Blayney et al 2012[10]	A statewide consortium (the MOQC) employed QOPI to measure the quality of outpatient cancer care in 36 outpatient practice groups. Adherence to EOL care processes was 73%, and 56% for symptom/toxicity process measures. These results drove specific interventions, which started to improve care. The model, with a third party assuming much data abstraction and consortium infrastructure maintenance cost, can bring together oncology providers and payers to measure quality and design interventions to improve care.
Jacobsen et al 2012[11]	Two years of performance on QOPI psychosocial measures from 166 practices shows that assessment of emotional well-being improved 64% to 73% ($P < .001$); however, action to address an identified problem only increased from 74% to 76% ($P = .41$). Assessment of psychosocial care for patients with cancer may promote psychosocial screening in patients but does not improve care provision.
Neuss et al 2011[12]	Description of QOPI and QOPI certification including measure performance through 2011. Measures with high concordance (recommended treatment of breast and colorectal cancers) and others where performance is lower (discussion of infertility risks and fertility preservation options and hospice enrollment) are contrasted. The growth of collaborative improvement networks incorporating QOPI and QOPI certification to assess and drive improvement activities within the collaborative groups are discussed.
Campion et al 2011[13]	The article reviews performance by QOPI participants on EOL care measures in 2010. Practices that participated in more than one round outperformed first-time participants on pain addressed appropriately before death. (65.8% *v* 46.9%). Repeat participants also performed significantly better than first-time participants in hospice and palliative care measures (65.6% *v* 54.7%).
Blayney et al 2009[14]	A description of the MOQC, a statewide quality improvement consortium and its partial financial support by BCBSM. BCBSM incentivized practice groups through MOQC to engage in quality measurement and improvement activities.
McNiff et al 2009[15]	The QOPI certification program development began in 2008 with launch in 2009. Practices can achieve a 3-year certification by achieving a threshold performance on a subset of the QOPI measures and complying with QOPI certification standards, primarily based on standards developed by ASCO and the Oncology Nursing Society.
Blayney et al 2009[7]	Five rounds of QOPI data from the University of Michigan Comprehensive Cancer Center showed high compliance to measures incorporated in the electronic medical record (such as pathology reports, smoking status, and cancer stage). Showing performance data to physicians was sufficient to change some aspects of physician behavior (such as chemotherapy administration in the last 2 weeks of life), but other improvements are likely to require structural change.
McNiff et al 2008[16]	Supportive care measures in QOPI as of 2007 and the integration of additional measures addressing dyspnea, quantification of pain, constipation management, emotional well-being assessment, treatment induced–infertility, and genetic evaluation of patients with breast and colorectal cancers is described.
Jabcobsen et al 2008[5]	The initial performance on 28 measures by 71 QOPI-participating practices is described. Change in composite scores for six different domains of care (core, EOL, symptom, breast, colon and rectum, and NHL) was compared between the two rounds. Mean composite score increased from 78.7% to 82.3% ($P < .05$). Bottom quartile performers demonstrated the greatest improvement (27% absolute change and 35% relative change).
McNiff et al 2006[17]	Historical information that provides the framework and constructs for the pilot QOPI program and key observations from the early development years are discussed.
Neuss et al 2005[4]	Results from the QOPI alpha or pilot group showed high concordance on some measures and statistically significant variation among practices for others, including assessing pain in patients close to death, documentation of informed consent for chemotherapy, and concordance with granulocytic and erythroid growth factor administration guidelines. Concordance with quality indicators significantly changed between survey rounds for several measures. Authors concluded that QOPI provides a tool for practice self-examination that can promote excellence in cancer care.

Abbreviations: ASCO, American Society of Clinical Oncology; BCBSM, BlueCross BlueShield of Michigan; EOL, end-of-life; MOQC, Michigan Oncology Quality Consortium; NHL, non-Hodgkin lymphoma; QOPI, Quality Oncology Practice Initiative.

in 43 states. QOPI certification program sites vary from a single physician practice to large multisite cancer programs and academic medical centers.

The need to expand and evolve to meet participants' needs. In the decade since the QOPI pilot began, external scrutiny and professional expectations for quality monitoring have expanded dramatically. Although QOPI was initiated as a grassroots self-assessment initiative, QOPI leaders found that the program had the potential to meet emerging requirements. This includes performance improvement requirements for medical board maintenance of certification and for continuing medical education. In addition, at the time of this writing, 75 medical oncology fellowship programs have used QOPI as a pathway to meet American College of Graduate Medical Education (ACGME) performance improvement training recommendations.

The Path Forward: Plans and Ideas for the Future

QOPI has demonstrated success with quality assessment, but ASCO and QOPI leadership know that the program must change and expand to meet ongoing member needs and the shifting environment. We seek to provide improvement tools and methodologies to continuously improve quality and maximize outcomes and value in oncology practice. We also hope to make it easy for oncologists to truly engage in quality measurement and improvement to minimize concerns that quality improvement is to be delegated to administration

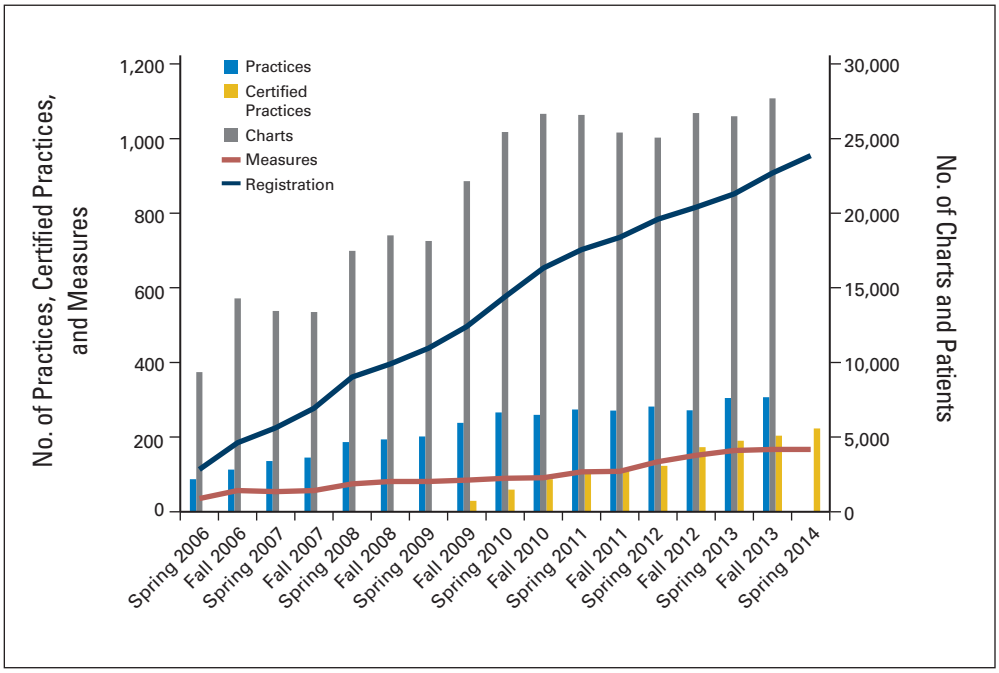

Fig 1. The growth of the Quality Oncology Practice Initiative program from its opening round in Spring 2006 through Spring 2014. Approximately 450 practices participate each year, representing nearly 4,000 oncologists throughout the United States and more than 24,000 patients.

and not involve the oncologist. To get there, several priorities have been identified for the next few years.

EHR reporting option. A growing proportion of oncology practices have implemented an EHR system. Despite their limitations and challenges, EHRs have the potential to facilitate quality monitoring as a secondary use of clinical data. EHR penetration now exceeds 60% to 75%[20] of oncology practices. In response, ASCO is developing a feasible and practical solution to reduce or eliminate manual data abstraction and allow data to be uploaded from EHR-generated reports into the QOPI system. Both options—the EHR upload (known as eQOPI) and the classic web portal entry—will be concurrently available and will allow practices to report electronically when they and/or their EHR systems are ready. Along with ease of reporting, the EHR (eQOPI) option should allow for submission of data from a complete patient population (instead of the sampling methodology employed for manual abstraction) and for more frequent assessment.

Regulatory concerns. QOPI was designed for minimum patient risk and does not require practice-level institutional review board review nor patient consent. In the past decade, the legal issues associated with the QOPI program have become more complex. Ongoing monitoring is required to ensure compliance with changing US regulations necessary to maintain a HIPAA-compliant program and a HIPAA-defined limited data set and has included revising data use agreements and business associate agreements between ASCO and participating practices. Ansuring compliance with US regulatory burdens has consumed much legal time and resources during QOPI's development. Compliance with non-US regulatory regimes has limited QOPI offerings in non-US settings, although ASCO is beginning work to make QOPI more available to its non-US members.

Using Big Data to improve quality and facilitate rapid learning. In the future, QOPI reporting will be integrated into CancerLinQ, a real-time, bidirectional system for quality reporting, clinical decision support, and rapid learning.[18,21] CancerLinQ is ASCO's Big Data learning health system. It is based on a knowledge-generating computer network that will collect and analyze cancer care data from millions of patient visits and expert guidelines and feed that knowledge back to oncologists at the point of care. The program was conceived in response to the IOM's recommendations for establishing a learning health system for health care, and with CancerLinQ, all patients treated in any oncology office in the country will have the potential to access vetted state-of-the-art care and research without leaving the local community.

In 2013, ASCO demonstrated a CancerLinQ operating prototype, which gathered deidentified data from more than 177,000 patients with breast cancer who received treatments at hospitals and practices nationwide. Based on that early success, ASCO plans to make the first components of CancerLinQ available to physicians in 2015. This will include relevant data (some of which will be generated by natural language processing, bioinformatics techniques) on all types of cancer. CancerLinQ will eventually provide access to millions of deidentified patient records, expert guidelines, and relevant scientific literature to enable a faster learning cycle. Process measures and outcome measures, as well as patient comorbidity adjustment capabilities, will be features of CancerLinQ.

Focus on quality improvement. QOPI was launched to engage practices in self-examination rather than offer direct improvement support. The overall experience shows that QOPI participants improve on some measures but show little change on others.[8] Deficiencies in QOPI performance result from nonconcordance with recommended processes, incomplete documentation, or inaccurate audit.[10] Measures that are solely attributable to the behavior of a physician have proven more amenable to change, whereas measures that involve the patient care team are more challenging. The process of recommending an intervention to a patient and the patient agreeing to and accepting the intervention, is also a challenge. We have illustrated recommended and accepted measures in Table 1, so that if desired, specific interventions can be designed to narrow this gap.

These observations have spurred organized improvement activities.[22] Several collaborative groups of practices have come together directly[23] or with a third-party payer[14] or government agency sponsorship.[24] Until recently, ASCO did not have a program to support practices in implementing practice changes needed for improvement. ASCO leadership, including the Quality of Care Committee and ASCO board of directors, supported the recent launce of a formal Quality Training Program[25] for oncology teams and a Virtual Learning Collaborative[26] in palliative care. These programs will build direct improvement training and will support oncologists with the skills and resources needed to address locally identified quality gaps.

Additional validated measures, including outcome measures. We will continue to expand the QOPI measure set in response to requests from our participants and members. As the genetic nature of cancer risk is further understood, QOPI is developing measures to assess patient and family cancer risk and testing (Table 1, measures 51 and 51a, b, and c). An additional example is to support the "Choosing Wisely" campaign, which aims to support the practicing oncologist in guiding patient choice to minimize practices (including diagnostic testing and therapeutic choices) that have little or no value.[27,28] QOPI has developed and is testing measures inspired by the Choosing Wisely campaign (Table 1, measure 62c). A measure of performance status documentation is also in development to assess the use of chemotherapy in patients with poor performance status. Finally, interprofessional society collaboration for measure development, in this example measuring ovarian cancer quality of care, has been developed in collaboration with the Society of Gynecologic Oncology (Table 1 measure 91).

Along with this work, we will enhance measure testing and validation initiatives. Key areas for additional measure development include value-focused measures, clinical outcome measures and patient-reported outcome measures. Process measures will likely remain integral to the QOPI measure set, given that these are most useful to guiding improvement efforts; however, a better understanding of outcomes is crucial.

Enhance recognition and reach, including from accreditation agencies and payers. We will continue to position QOPI as a pathway to meet American College of Graduate Medical Education performance improvement training recommendations. QOPI will continue as a one-stop shop to help meet quality reporting needs. One important example in recent years is the ability for oncologists to use QOPI as a pathway to receive Part IV (performance improvement) points required for American Board of Internal Medicine maintenance of certification, and we are seeking to facilitate that process. QOPI is also being implemented as the quality assessment program for the National Committee for Quality Assurance–led oncology medical home pilot demonstration project. Perhaps most importantly, the Tax Relief and Health Care Act of 2012 paved the way for specialty society registries to be used as a reporting option for the Physician Quality Reporting System.

Summary

In 1999, the IOM issued a cancer quality report that spurred on QOPI development. In 2013, the IOM released a follow-up report.[29] The update reinforces that there is work yet to be accomplished; however, we believe that oncology has made significant progress since 1999 and that QOPI has contributed positively. Ongoing evolution of the QOPI program, under the careful guidance of oncology providers, is critical to maintaining the relevance and meaningfulness of the program to ASCO members and positive impact for their patients.

AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

Disclosures provided by the authors are available with this article at www.jco.org.

AUTHOR CONTRIBUTIONS

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