Insuring the Future of Quality Cancer Care

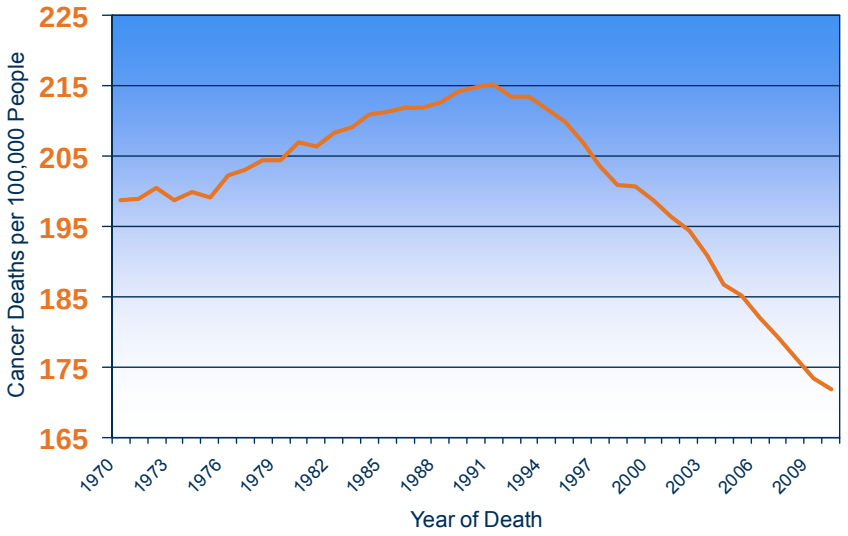
Richard L. Schilsky, MD

Chief Medical Officer

ASCO

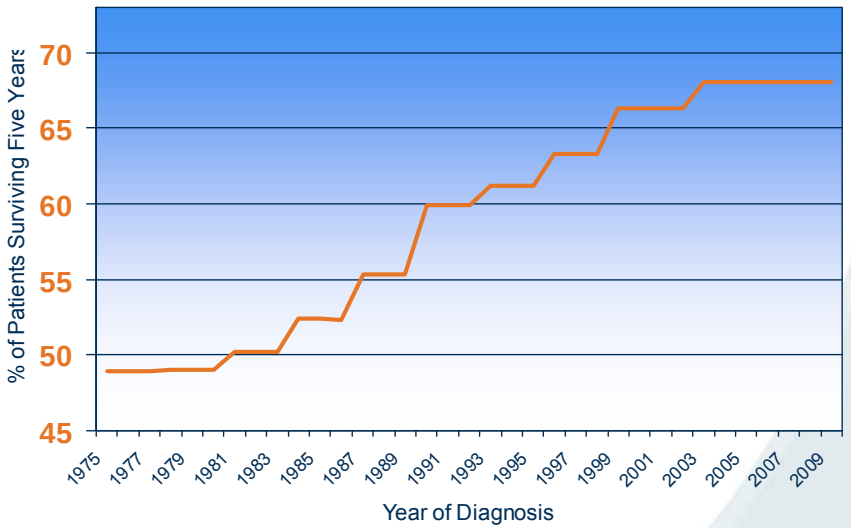
Good News

Mortality



Source: National Cancer Institute

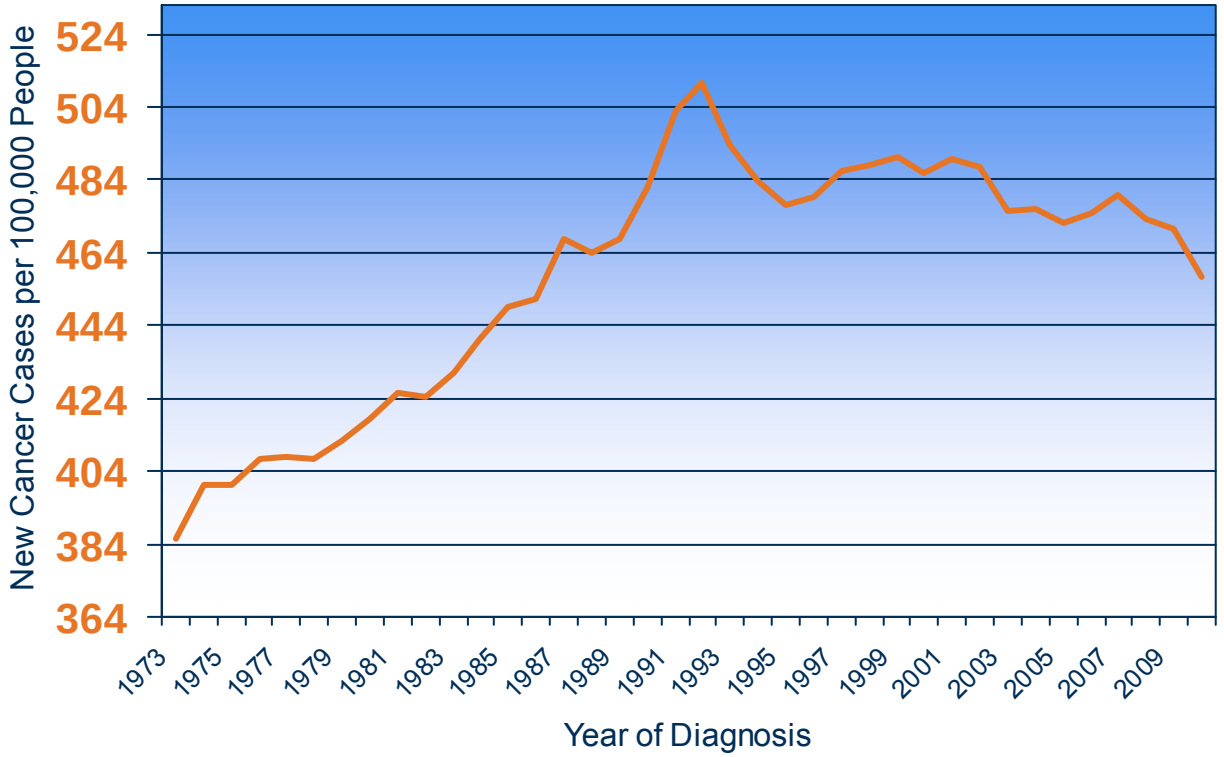
Five-Year Survival



Source: National Cancer Institute

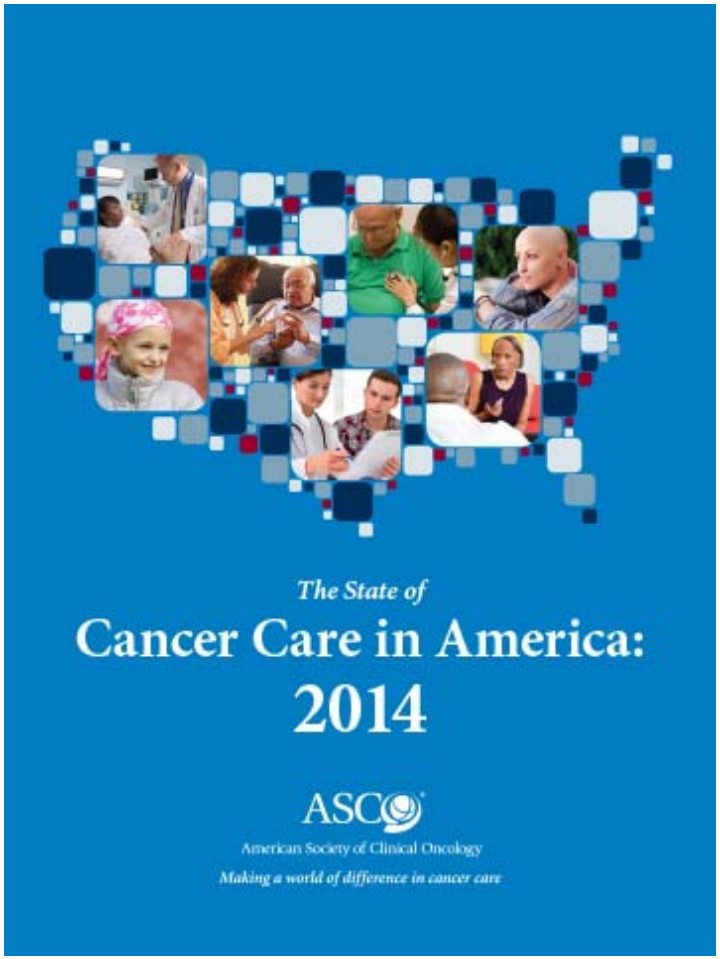
What's Ahead

New Cancer Cases



Source: National Cancer Institute

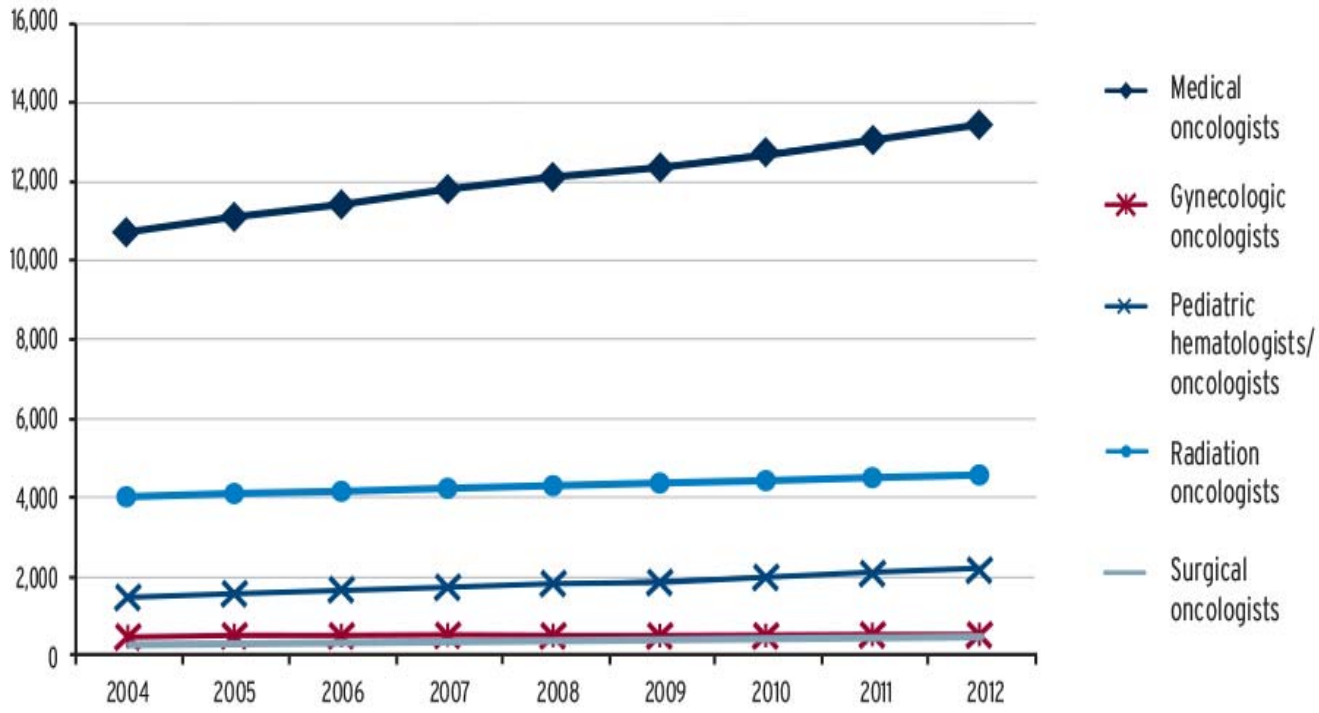
The Big Picture



Cancer Care Challenges

- By 2025, new US cancer cases up by 42%
- ACA adds 25 million newly insured
- Cancer survivors increasing to 18 million

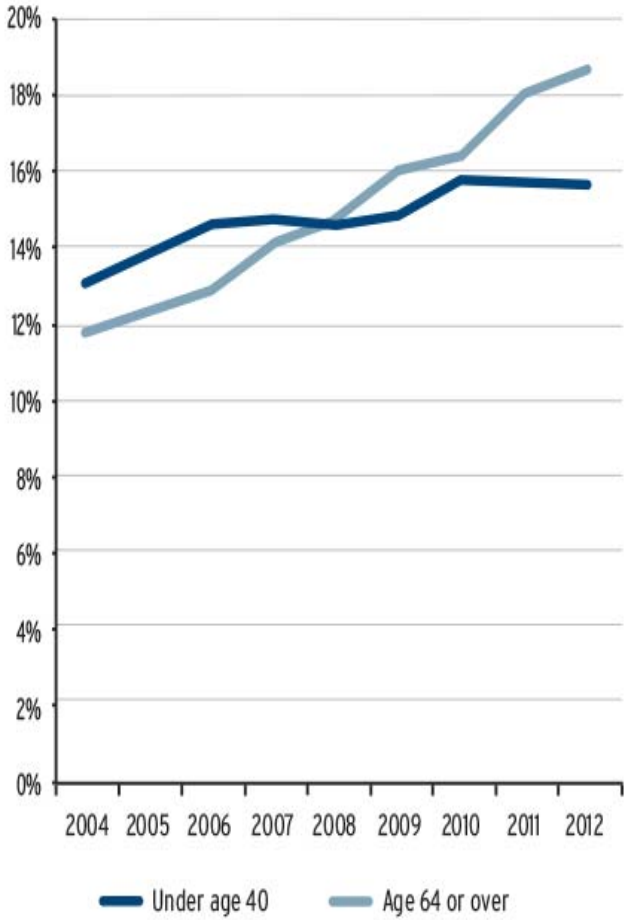
13,400 U.S. Medical Oncologists



Source: AMA Masterfile; Medical oncologists includes all physicians who identify as medical oncologists, hematologists, and hematologist/oncologists.

The State of Cancer Care in America: 2014, American Society of Clinical Oncology.

More Oncologists Over 64 Than Under 40



The State of Cancer Care in America: 2014, American Society of Clinical Oncology.

Supply-Demand Perspective

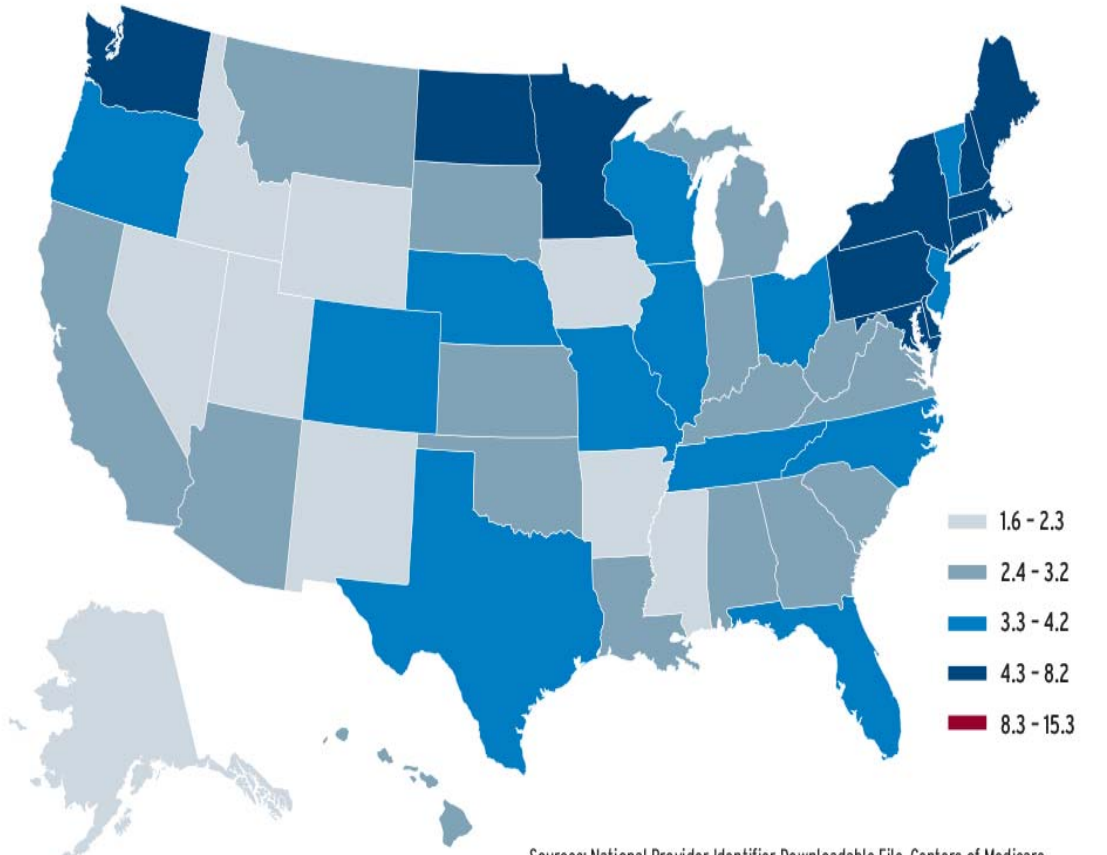
300 New Patients/per year

x 1,487 Oncologist Shortage

446,100 New Patients Face Challenges

Geographic Challenges

Oncologists per 100,000 Population by State



Sources: National Provider Identifier Downloadable File, Centers of Medicare and Medicaid Services (accessed August 12, 2013) and 2013 TIGER/Line® Shapefiles, U.S. Census Bureau

The State of Cancer Care in America: 2014, American Society of Clinical Oncology.

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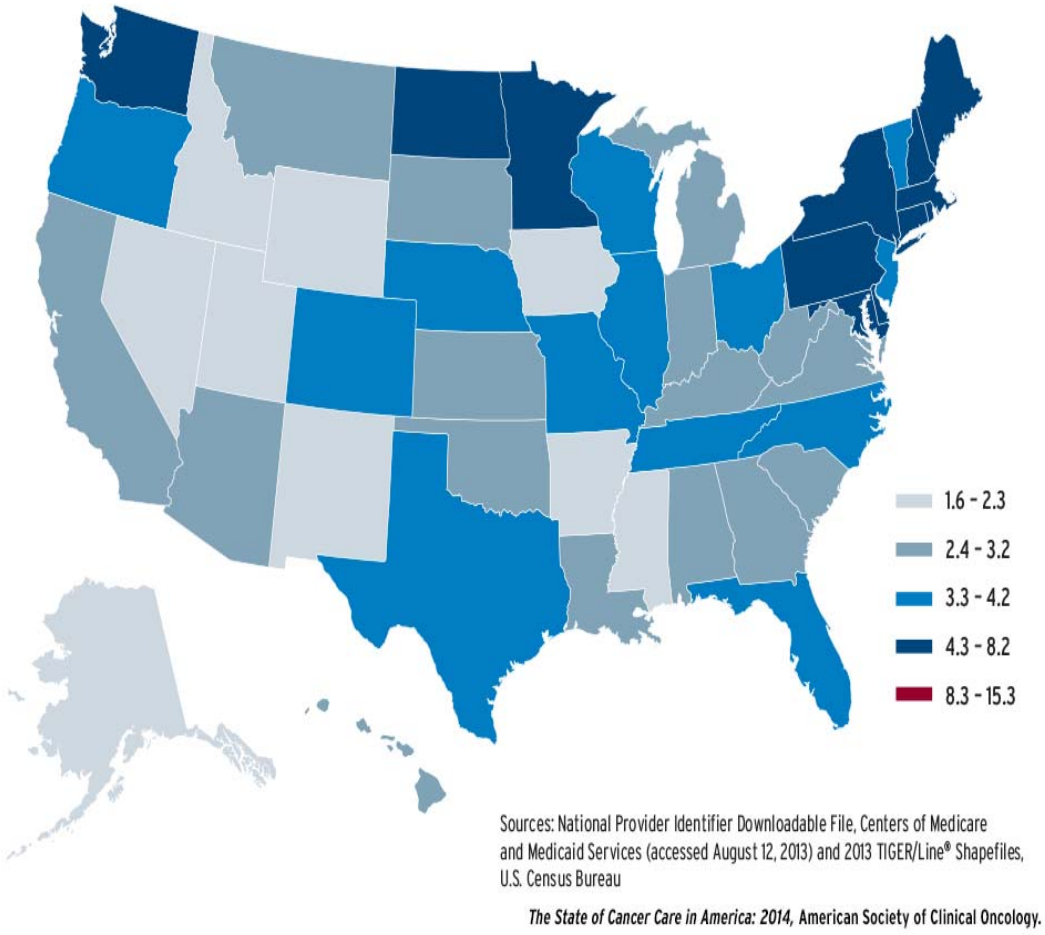
Cancer Care in Rural America

Oncologists per 100,000 Population by State



Sources: National Provider Identifier Downloadable File, Centers of Medicare and Medicaid Services (accessed August 12, 2013) and 2013 TIGER/Line® Shapefiles, U.S. Census Bureau

The State of Cancer Care in America: 2014, American Society of Clinical Oncology.

- 1 in 5 Americans live in rural areas
- 1 in 33 oncologists practice in rural areas

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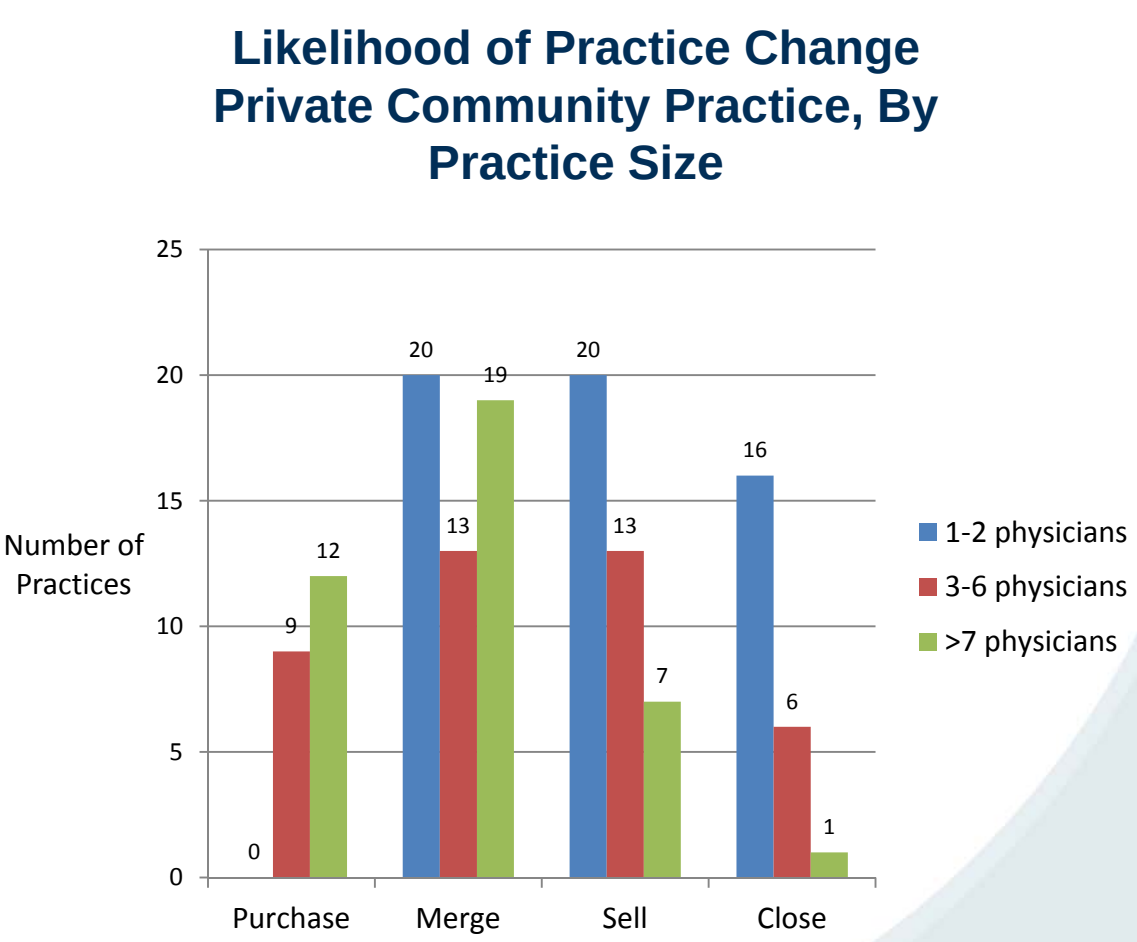
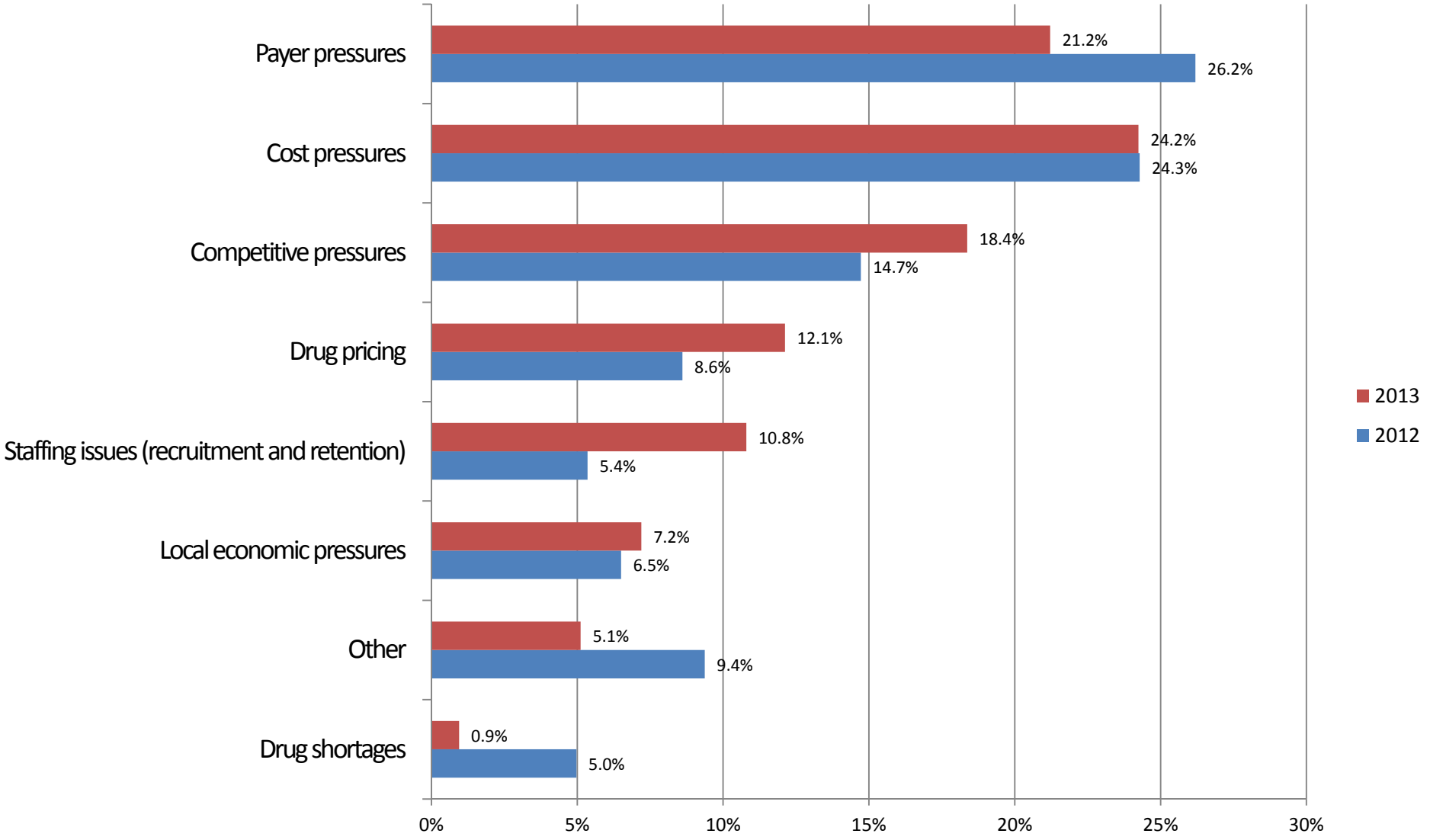
Community Practices At Risk

- 25% reduction in private practices since 2012 census
- 2/3 of smaller practices anticipate sale, merger or closing in next year—double that reported overall
- Small, medium practices see >1/3 new patients



Top Concerns



Rough Waters for Practices

- Economic pressures
- Political turbulence
- General disruption across medicine
  - Sequestration
  - ICD-10
  - PQRS, Meaningful Use
  - Health Reform
    - ACOs, shifts in practice environment
    - Performance based payment
    - Wave of newly insured
    - Uncertainty

Medicare Sequestration

- 2% Medicare sequestration took effect April 2013
- Cut applied to both payments for Part B drugs and 6% services payment
- After accounting for patient copays, payment for Part B drugs decreased from ASP+6% to ASP+4.3%
- Difference in service fee: 6% - 4.3% = 1.7%
- Medicare is paying 28% less on the service fee

Impact of Sequestration on Practices

Survey Findings:

- **One in four**: no new Medicare Advantage patients
- **Half**: send their Mdicare patients without supplemental insurance to hospital for chemo
- **Three fourths**: difficulty covering the costs of drugs
- **One in five**: have or are considering closing satellite/outreach clinics

HR 1416: Cancer Patient Protection Act

- Introduced April 2013
- Exempts Part B drugs from sequestration
- 123 co-sponsors
- Support in House Energy & Commerce Health Subcommittee
- No Senate bill
- Uphill battle…but we are still pursuing

Renee Ellmers (R-NC)

SGR Rollercoaster

Dec 2009:	Congress freezes rates for two months
Mar 2010:	CMS holds claims
Apr 2010:	CMS advises physicians to hold claims
Jun 2010:	Congress delays cut until November 30
Nov 2010:	Congress freezes rates for one month
Dec 2010:	Congress delays cut for one-year
Feb 2011:	Congress delays cut with 10-month patch
Feb 2012:	Congress delays cut until Jan 2013
Jan 2013:	Congress delays cut for one year
Dec 2013:	Congress delays cut until April 1, 2014
Mar 2014:	Congress delays cut until March 31, 2015

Cumulative cut now ~25%

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Repeal SGR Formula

SGR Repeal and Medicare Provider Payment Modernization Act of 2014

II

113TH CONGRESS
2D SESSION

S. 2000

To amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate and improve Medicare payments for physicians and other professionals, and for other purposes.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 6, 2014

Mr. BAUCUS (for himself and Mr. HATCH) introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

To amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate and improve Medicare payments for physicians and other professionals, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "SGR Repeal and Medicare Provider Payment Modernization Act of 2014".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

I

113TH CONGRESS
2D SESSION

H. R. 4015

To amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate and improve Medicare payments for physicians and other professionals, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 6, 2014

Mr. BURGESS (for himself, Mr. UPTON, Mr. CAMP, Mr. WAXMAN, Mr. LEVIN, Mr. PITTS, Mr. BRADY of Texas, Mr. PALLONE, Mr. MCDERMOTT, and Mr. BOUSTANY) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate and improve Medicare payments for physicians and other professionals, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

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Compromise Bill: HR 4015/S 2000

End of rollercoaster ride?

- Immediate repeal of SGR
- Annual update of .5% for five years
- Streamlines all incentive payments into new Merit-Based Incentive Payment System (MIPS)
- 5% incentive payment for physicians in Alternative Payment Models
- Encourages specialty specific Alternative Payment Models
- Credit for participation in QCDRs

Where are We Now…

- After a decade of patches to prevent SGR cuts, 3 committees of jurisdiction reached consensus
  - Bipartisan support
  - Physician community endorsed
- Partisan disagreements about how to pay for it stalled bill
- Congress instead enacted patch until March 31, 2015

Taking Action: SGR

- Continue to work with committees in Congress
- Endorsing SGR Repeal legislation
- Partnering with other medical societies (ads and other outreach)

…..paying attention to offsets ($120-150B)

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The ASCO Policy Statement on the 340B Drug Pricing Program

- In December 2012, the State Affiliate Council brought concerns about the 340B program to the ASCO Board
- Workgroup formed representing several committees and groups at ASCO
- ASCO position paper released in April 2014

Benefits and Areas of Concern

- Essential that uninsured, under-insured, and indigent patients have access to care
- Allows institutions that truly serve the vulnerable to maintain operations

…but

- Program has expanded beyond original intent
- Has created an “unlevel” playing field
- Program needs reform so that resources go to the patients that need them, regardless of setting

Recommendations

1. **Policymakers should focus on how to best meet the original intent of the program**

- Congress & HRSA should require covered entities to provide a full, comprehensive accounting of the amount of 340B savings and the percent reinvested into care for uninsured, underinsured, and Medicaid patients on an annual basis

2. **Policymakers should adopt policy changes that address the size and future growth of the 340B Drug Pricing Program.**

- Congress should discard the current DSH formula, and other parameters derived from inpatient data, for determining eligibility for an outpatient program
- Replace with a formula that considers the percent of underinsured / uninsured patients treated in the outpatient setting

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Recommendations Cont.

3. Issue guidance to clarify relevant definitions and provide funding for key oversight activities

- define and clarify the term “patient”
- HRSA should receive appropriate level of funding

4. Place special emphasis on any adverse impacts that the 340B program has on patient access

- Consider if recent/current expansion of the program affects availability of community oncology practices
- 340B program could be better targeted to truly needy patients by appropriately identifying those entities that serve such patients – regardless of site of care

Consolidated Payments for Oncology Care (CPOC)

- Flexible payment
  - Patient centered
  - Better match to services we provide/patients need
- Simpler billing structure
- More predictable revenue
- Incentivize high quality, high-value care
- Support coordinated, patient-centered care

Components of CPOC

- The Quality Oncology Practice Initiative
- A Chemotherapy Management Fee
- Value Based Pathways
- Monthly Episodes of Care/Bundled Payments
- Care coordination/ Patient – centered Medical Oncology Home

Current vs. Proposed Payments

E&M (new patient)
E&M (established patient)
Consultations
Chemotherapy administration / therapeutic injections / hydration

New patient payment
Treatment month payment
Transition of treatment payment
Active monitoring month payment

6% of ASP+6% could be folded into treatment month payments once an alternative to buy and bill is developed and sufficiently tested.

Episode-based Payment Plan

Magnitude of Proposed Payment Components Relative to New Patient Payment		
New Patient Payment		100%
Treatment Month Payment	Level 1	25%
	Level 2	43%
	Level 3	61%
	Level 4	80%
Active Monitoring Month Payment	Level 1	2%
	Level 2	10%
	Level 3	25%
Transition of Treatment Payment (in addition to Treatment Month or Active Monitoring Month Payment)	Level 1	30%
	Level 2	50%
Clinical Trial Payment		5%

Continued FFS Payments

- Laboratory tests
- Bone marrow biopsies
- Portable pumps
- Blood transfusions
- (list not all inclusive)

Additional Payment Adjustments

- Quality measures phased in over time
- Pathways, two stages:
  - Adherence
  - Use of certified pathways
- Resource utilization
  - OMH
  - ER and hospital admissions
- Clinical Trials
  - Higher Treatment Month and Non-Treatment Month payments for enrolled patients

Expected Impacts

- More flexibility for practices
- Practices accountable for quality of care and costs
- Simplification: replaces 58 codes with 11 codes

Moving Forward

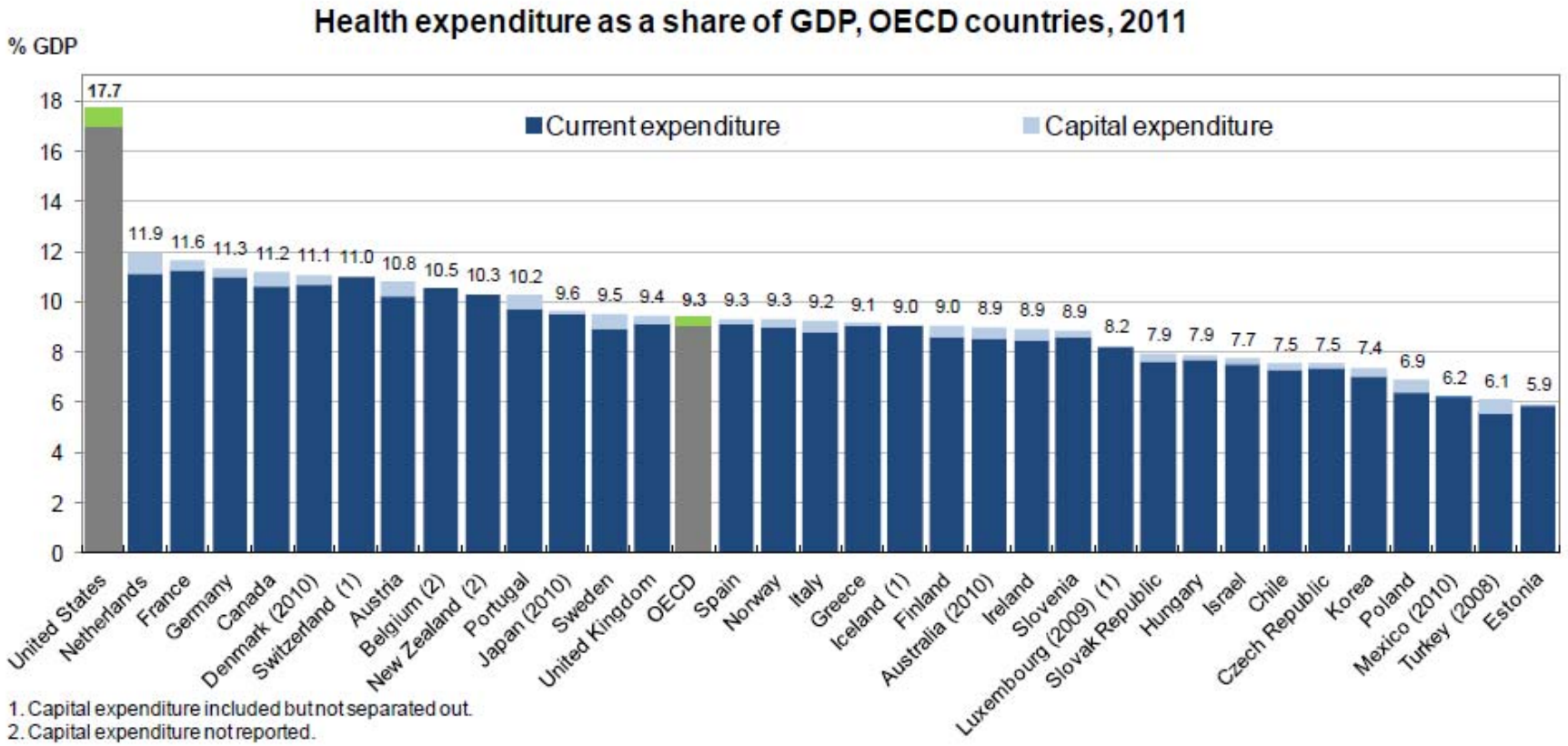
- Ongoing testing/refining of the model
- Seeking feedback on model from ASCO members and others in the cancer community
- Discussions with Congress and CMS

Seeking Your Feedback

More information at:

www.asco.org/paymentreform

US Health Spending at 17.7% of GDP is ~50% Greater than Others (and Still Rising)

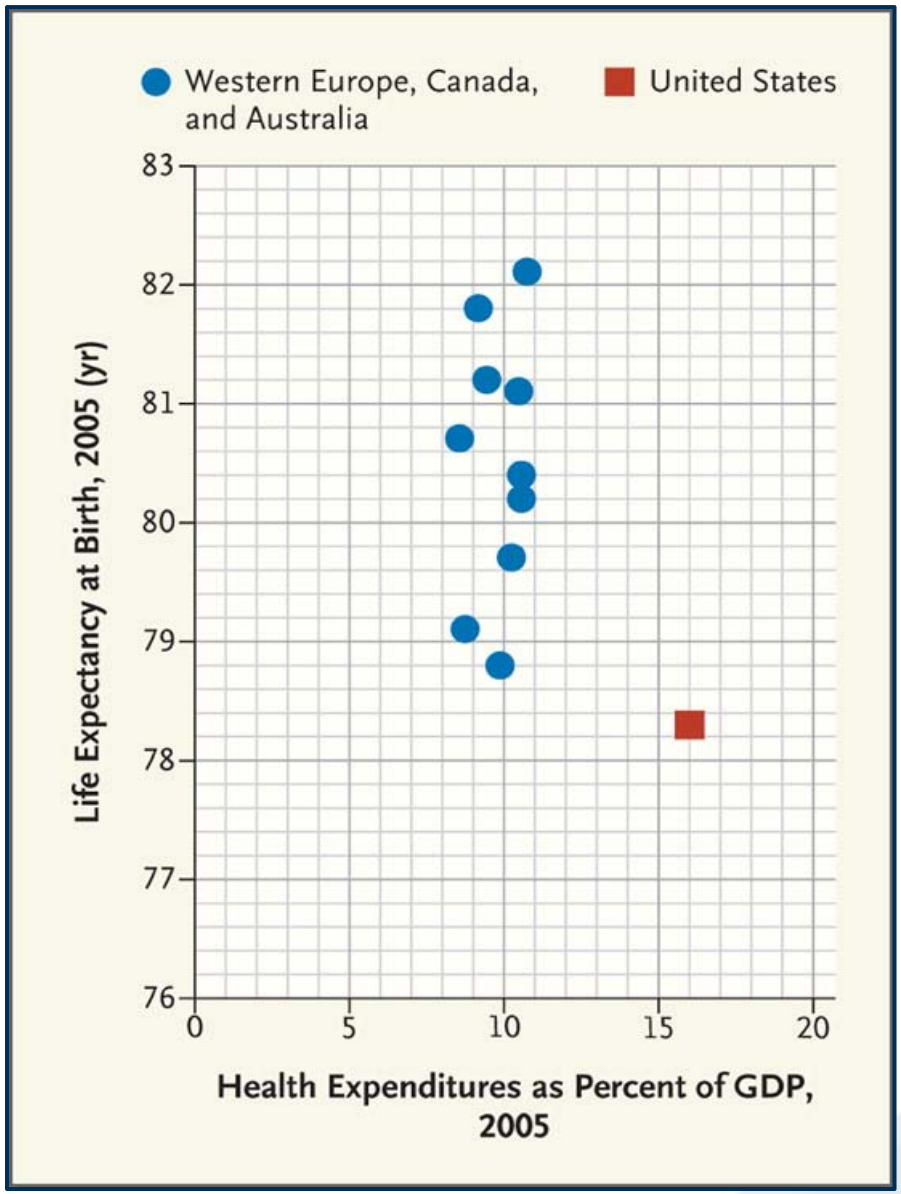


Projected US Health Spending 2020 → 20% GDP

Kehhan SP, Cuckler GI, Sisko AM, Madison AJ, Smith SD, Lizonito JM, Poisal JA and olfe CJ. National Health Expenditure Projections: Modest Annual Growth Until Coverage Expands And Economic Growth Accelerates. Health Affairs. 2012 Jul;31(7):1600-12.

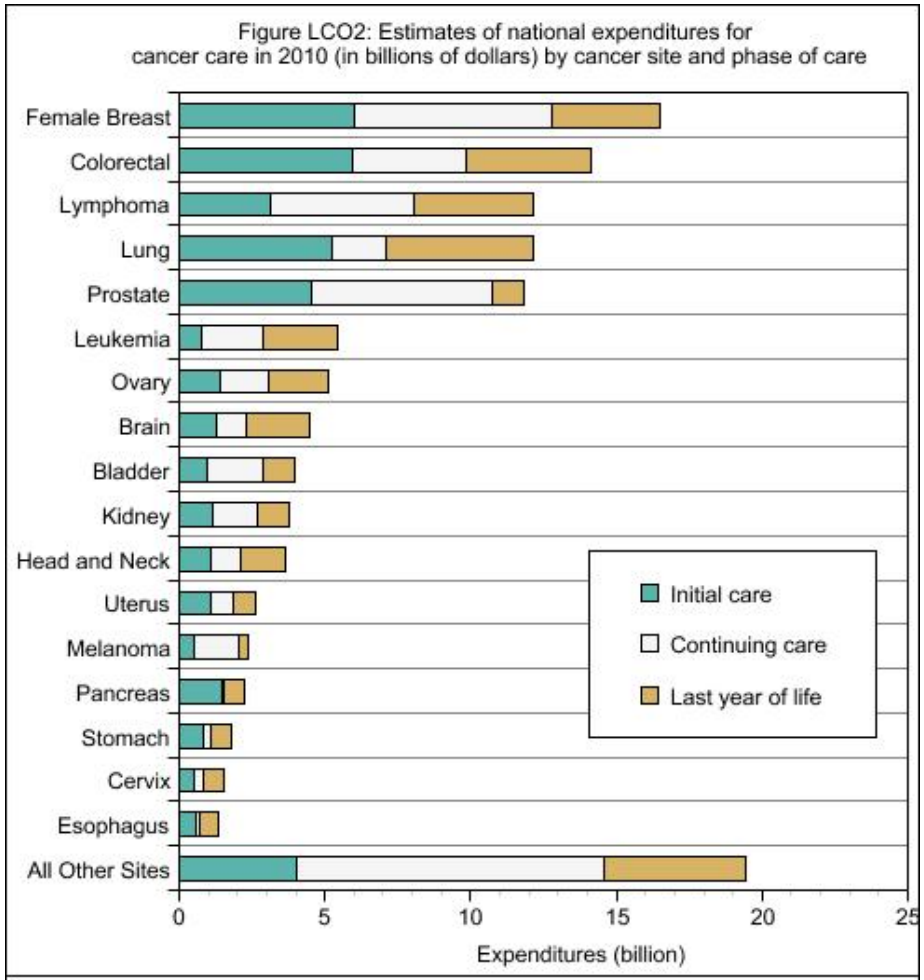
Higher Spending Does Not Increase Life Expectancy

Health Care Expenditures and Life Expectancy (2005)



Fuchs VR, Milstein A. N Engl J Med 2011;364:1985-19

Cost of Cancer Care is Rising

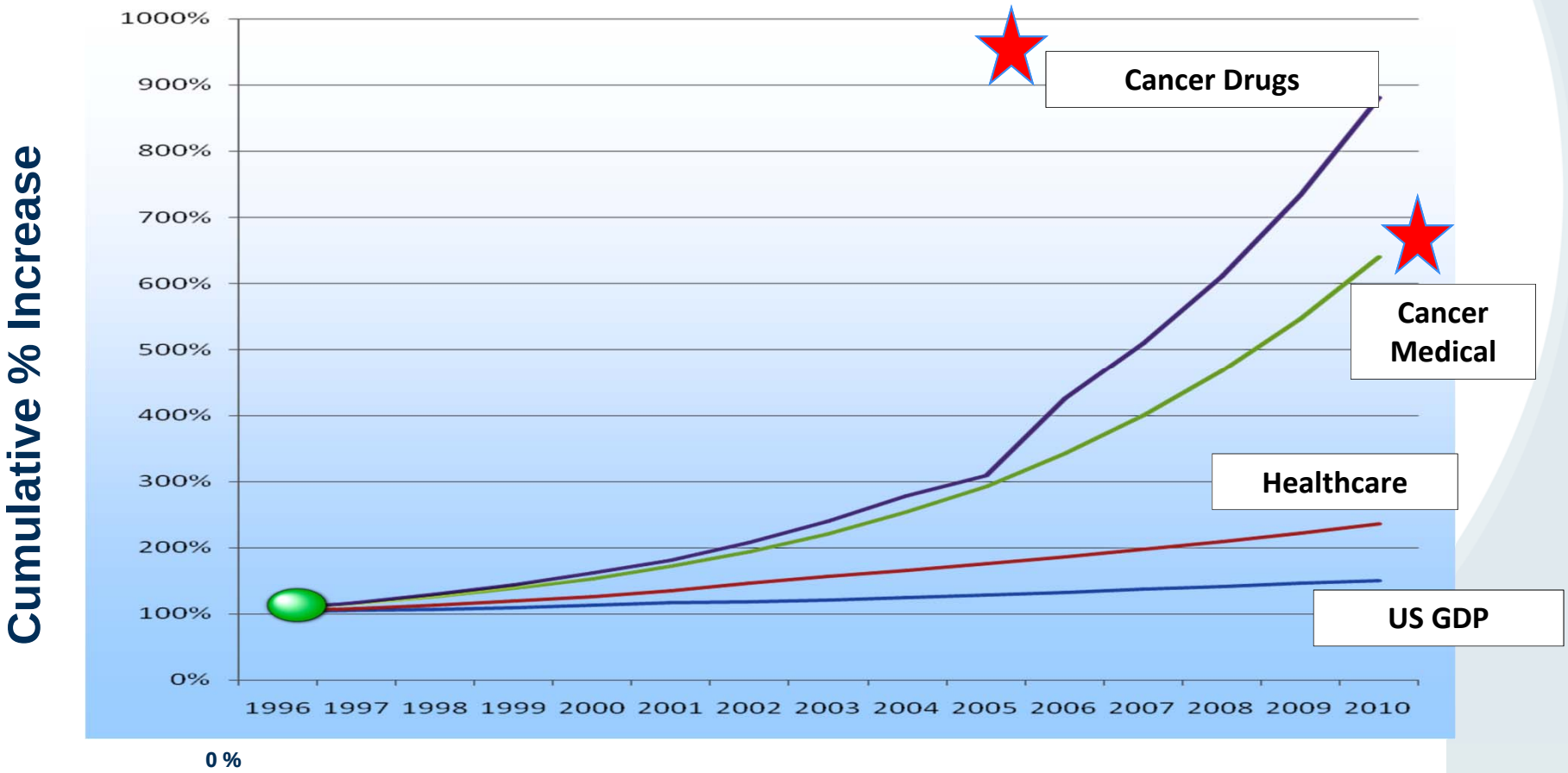


Source: Mariotto AB, Yabroff KR, Shao Y, Feuer EJ, Brown ML. Projections of the cost of c care in the U.S.: 2010-2020. J Natl Cancer Inst 2011; 103(2):117-28.
Cancer Prevalence and Cost of Care Projections: http://costprojections.cancer.gov/
Cost estimates expressed in 2010 dollars using CMS cost adjusters and adjusted for out- of pocket expenditures, including co-payments and deductibles.
Estimates for the population younger than 65 were developed using ratios of cost in the you than 65 and older 65 populations from studies conducted in managed care populations.

→ $125 billion in **2010**

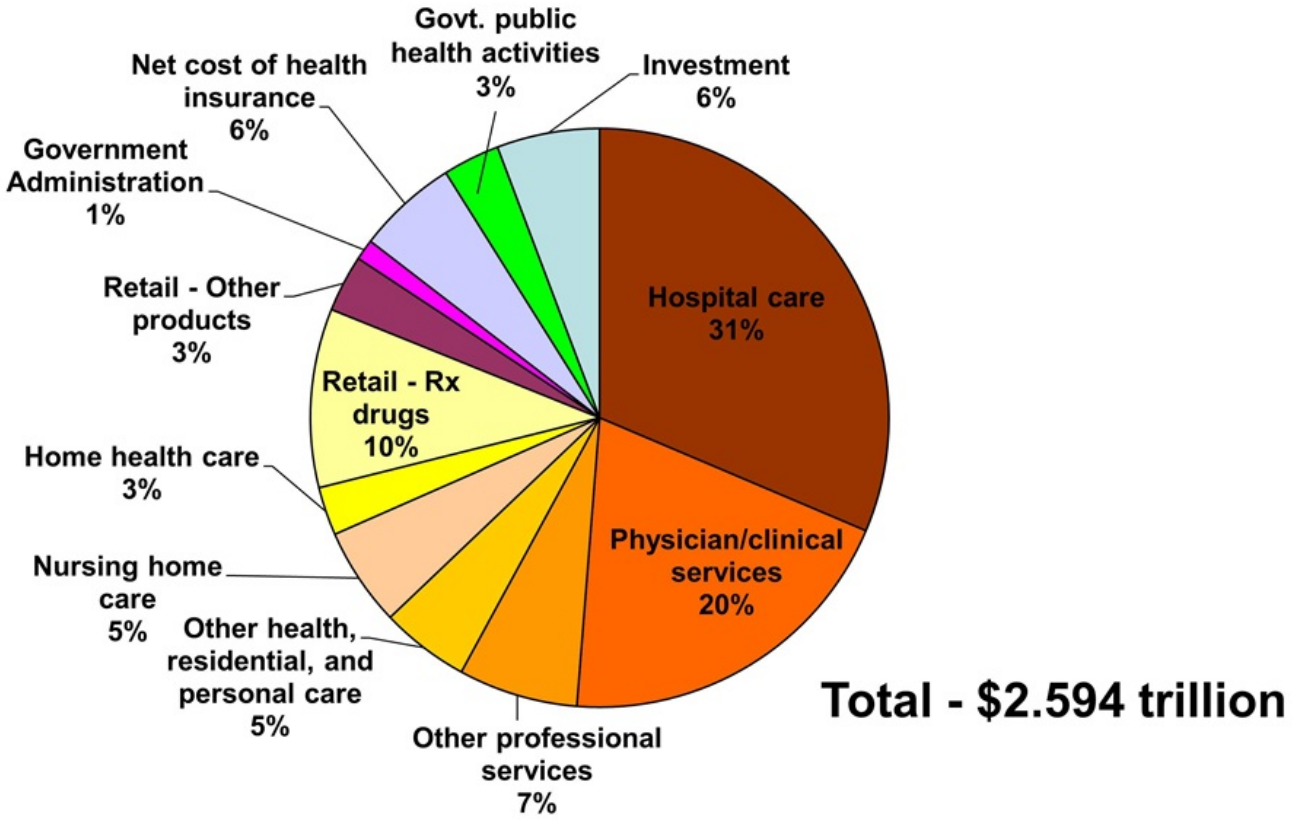
→ $175 billion in **2020**

Cancer Care Costs Rising Faster than Overall Healthcare



Source: Blue Cross Blue Shield Association

National Health Expenditures, 2010

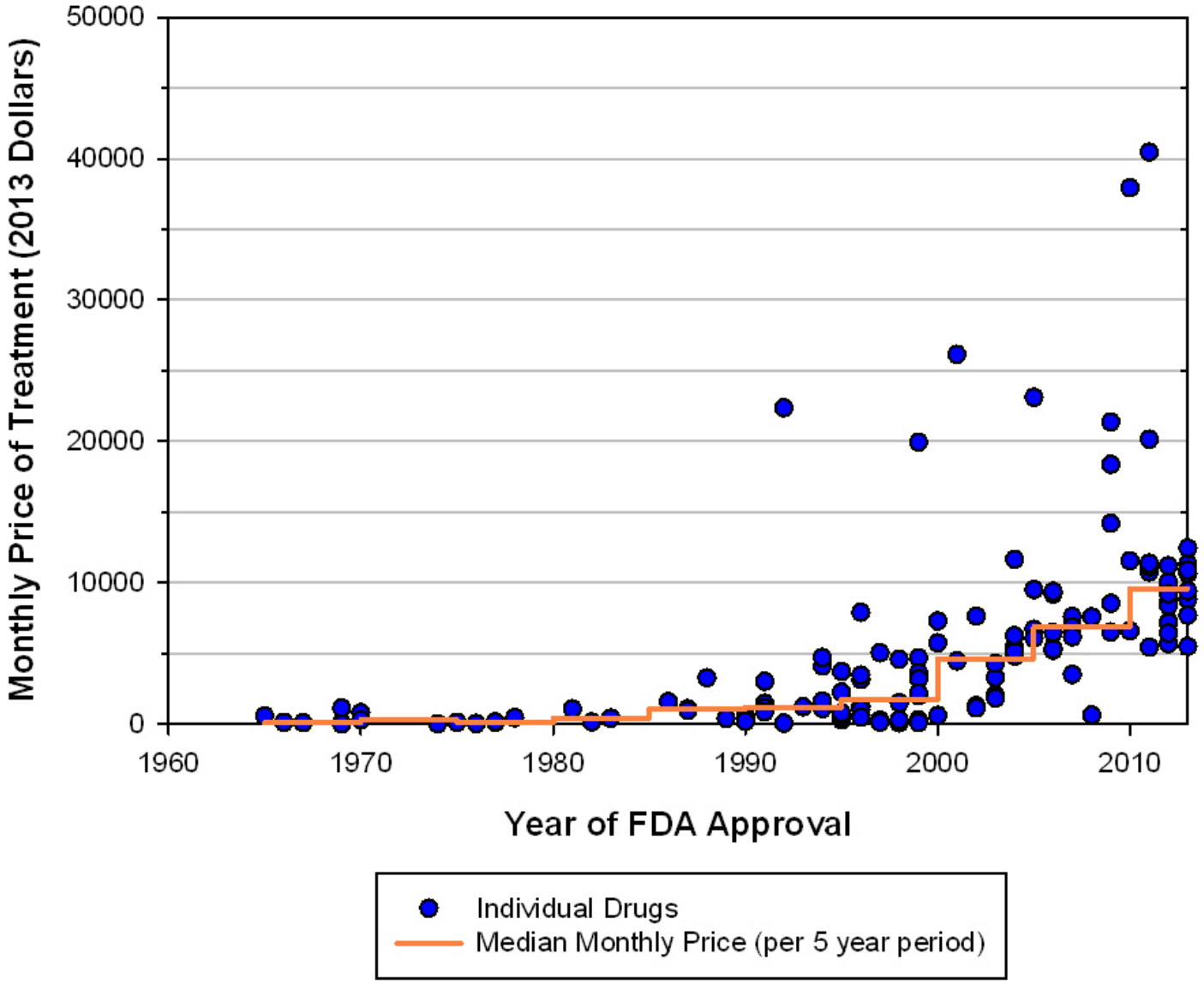


Source: Martin A.B. et. al., "Growth In US Health Spending Remained Slow in 2010; Health Share of Gross Domestic Product Was Unchanged from 2009," *Health Affairs*, 2012.

Hospitals and Providers a large fraction

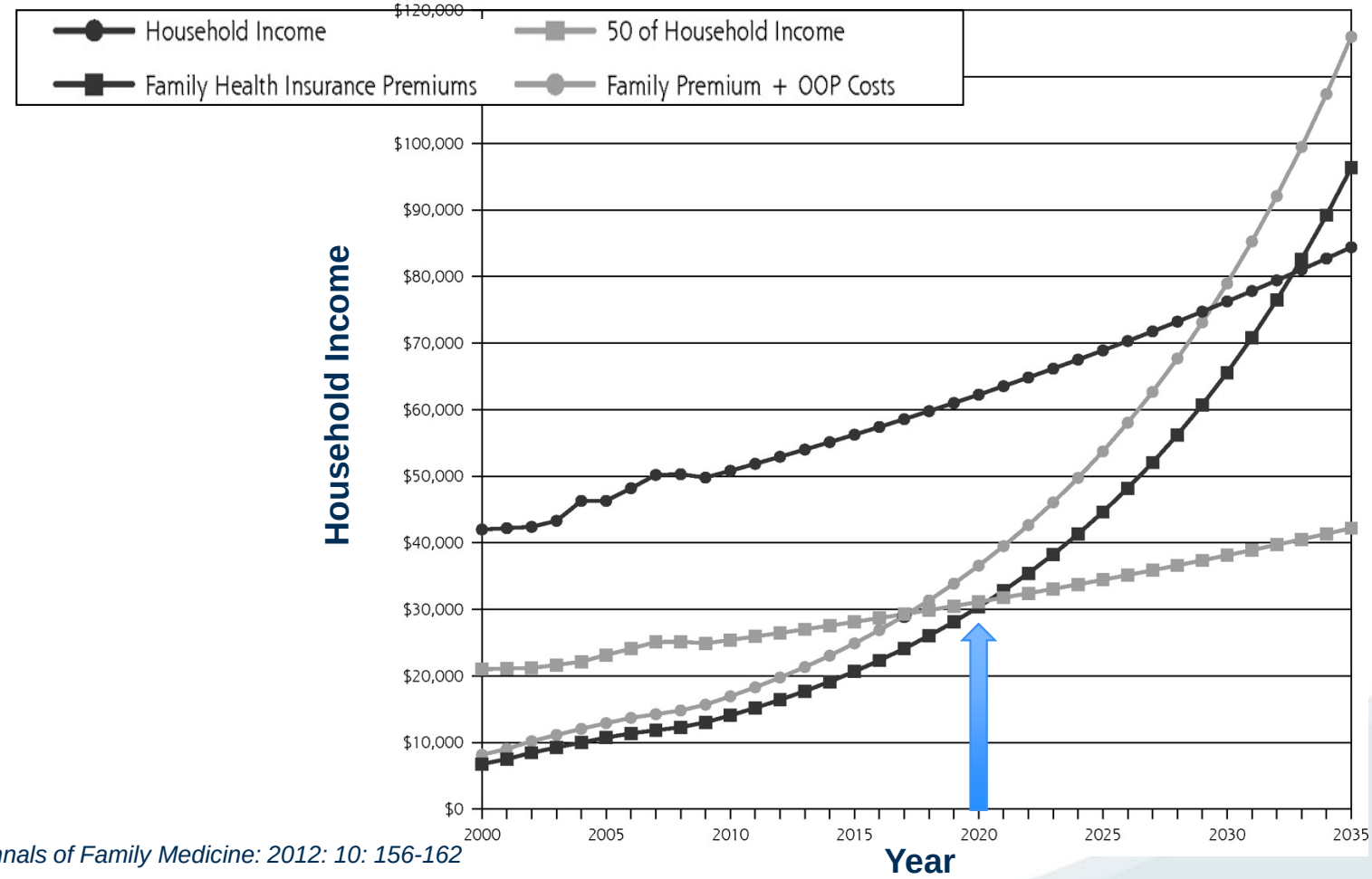
Monthly and Median Costs of Cancer Drugs at the Time of FDA Approval

1965 - 2013



Patients are Bearing More of the Costs

Projected family health insurance premium costs and average household income



Annals of Family Medicine: 2012: 10: 156-162

Taking Action: Cost and Value

- Value Task Force developing framework
  - Shared with CPC and State Affiliate Council
  - Value incorporated into the Annual Meeting

- Drug Cost Summit
  - Industry
  - Providers
  - Payers
  - Patients

What is “Value”?

“the regard that something is held to deserve; the importance, worth, or usefulness of something.”

$$\text{Value} = \frac{\text{Benefit(s)}}{(\text{Financial Cost} + \text{Non-financial Cost})}$$

ASCO's Efforts to Lower Costs, Increase Value

- Promoting Adherence to Evidence-Based Medicine: ASCO Guidelines
- Participating in & Promoting "Choosing Wisely"
- Commitment to Quality Improvement: QOPI
- Working with Payers: Integration of Quality Measures into Reimbursement Decision-Making
- Cultivating a Learning Healthcare System: CancerLinQ
- Establishing Clinically Meaningful Outcomes in Cancer Research
- Payment Reform
- The Value in Cancer Care Task Force

ASCO's Value Framework

- Designed to enable comparison of a new treatment with an existing treatment or, if there is no effective therapy, with best supportive care.
- Assesses value based on three primary parameters: Clinical Benefit, Toxicity, and Cost.
  - Clinical Benefit and Toxicity are combined to form a **Net Health Benefit Score**, then Cost is integrated to derive an overall **Value Score** for an oncology regimen.

- Two versions of the framework have been created: one for advanced (metastatic) disease and one for use in the adjuvant setting.
- In final stages of development for public release later this year.

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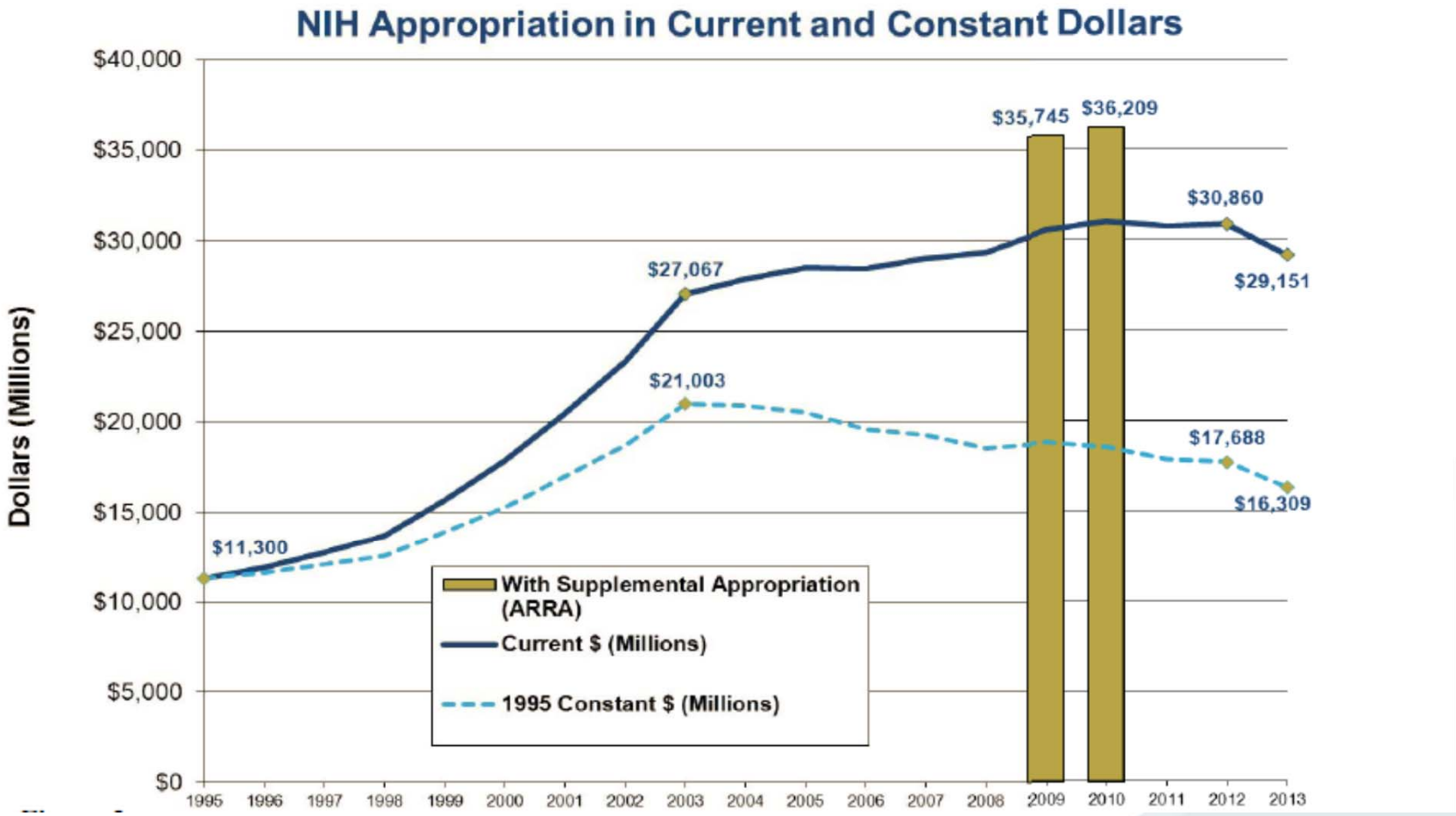
NIH Appropriation 1995-2013



FY14 Research Funding

	NIH	NCI	FDA
FY14 Final	$29.9 billion	$4.9 billion	$2.6 billion
Increase over FY13	+ $1 billion (3.5%)	$144 million (3%)	$182 million (7.1%)
Comparison to Pre-sequester level	- $700 million (2.3%)	-$200 million (4%)	+ 100 million (3.8%)

Impact of Sequestration on Research

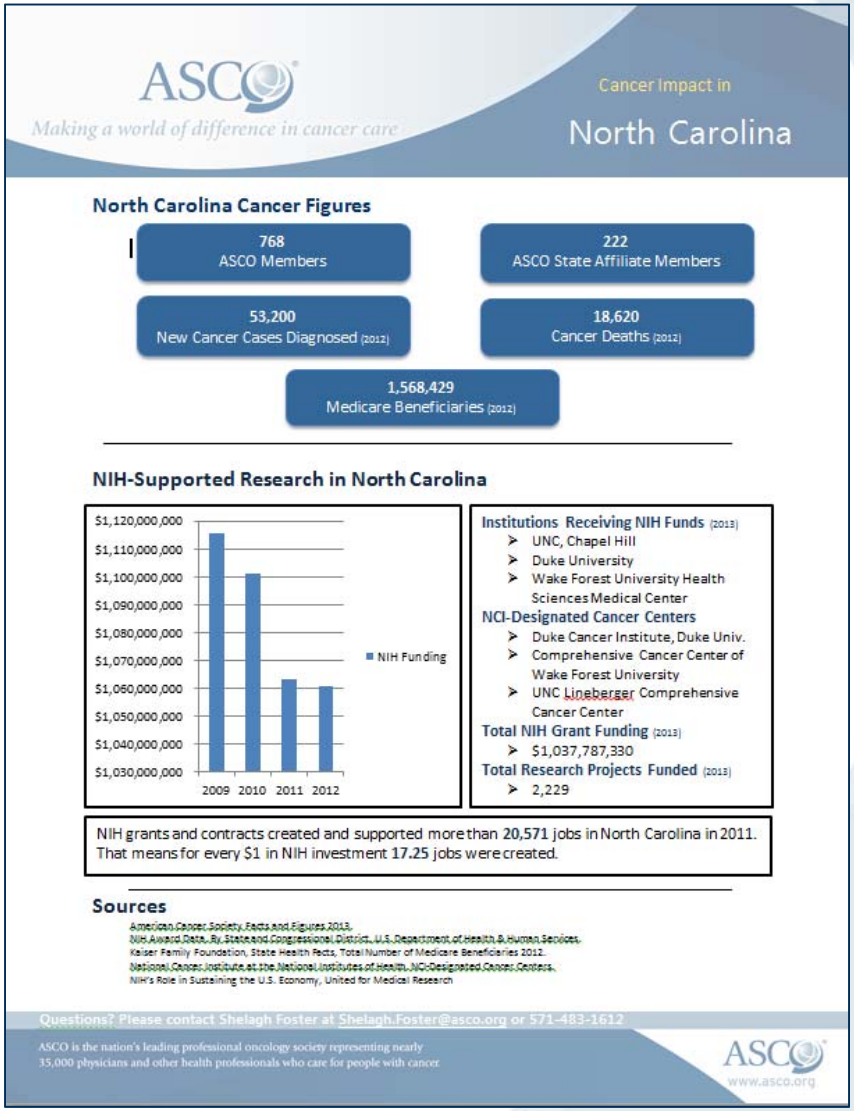
- **75 percent** said their research budgets were cut
- **38 percent** have reduced their time spent on research
- **35 percent** have had to lay off staff
- **28 percent** have decided to participate in fewer federally-funded clinical trials
- **23 percent** have had to limit patient enrollment on a clinical trial

Taking Action: Research Funding

- Clinical Cancer Advances
- Coalition efforts
- Direct lobbying

State Initiatives

- Targeted Grassroots Efforts with State Affiliates
- State-specific information sheets
- Meet with members of Congress in the district or in D.C.



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Making a world of difference in cancer care

Cancer Impact in
North Carolina

North Carolina Cancer Figures

768 ASCO Members	222 ASCO State Affiliate Members
53,200 New Cancer Cases Diagnosed (2012)	18,620 Cancer Deaths (2012)
1,568,429 Medicare Beneficiaries (2012)	

NIH-Supported Research in North Carolina

Institutions Receiving NIH Funds (2013)
- UNC, Chapel Hill
- Duke University
- Wake Forest University Health Sciences Medical Center

NCI-Designated Cancer Centers
- Duke Cancer Institute, Duke Univ.
- Comprehensive Cancer Center of Wake Forest University
- UNC Lineberger Comprehensive Cancer Center

Total NIH Grant Funding (2013)
- $1,037,787,330

Total Research Projects Funded (2013)
- 2,229

NIH grants and contracts created and supported more than **20,571** jobs in North Carolina in 2011. That means for every $1 in NIH investment **17.25** jobs were created.

Sources

American Cancer Society, Facts and Figures 2013.
NIH Award Data, By State and Congressional District, U.S. Department of Health & Human Services.
Kaiser Family Foundation, State Health Facts, Total Number of Medicare Beneficiaries 2012.
National Cancer Institute at the National Institutes of Health, NCI-Designated Cancer Centers.
NIH's Role in Sustaining the U.S. Economy, United for Medical Research

Questions? Please contact Shelagh Foster at Shelagh.Foster@asco.org or 571-483-1612

ASCO is the nation's leading professional oncology society representing nearly 35,000 physicians and other health professionals who care for people with cancer.

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Federally Funded Research

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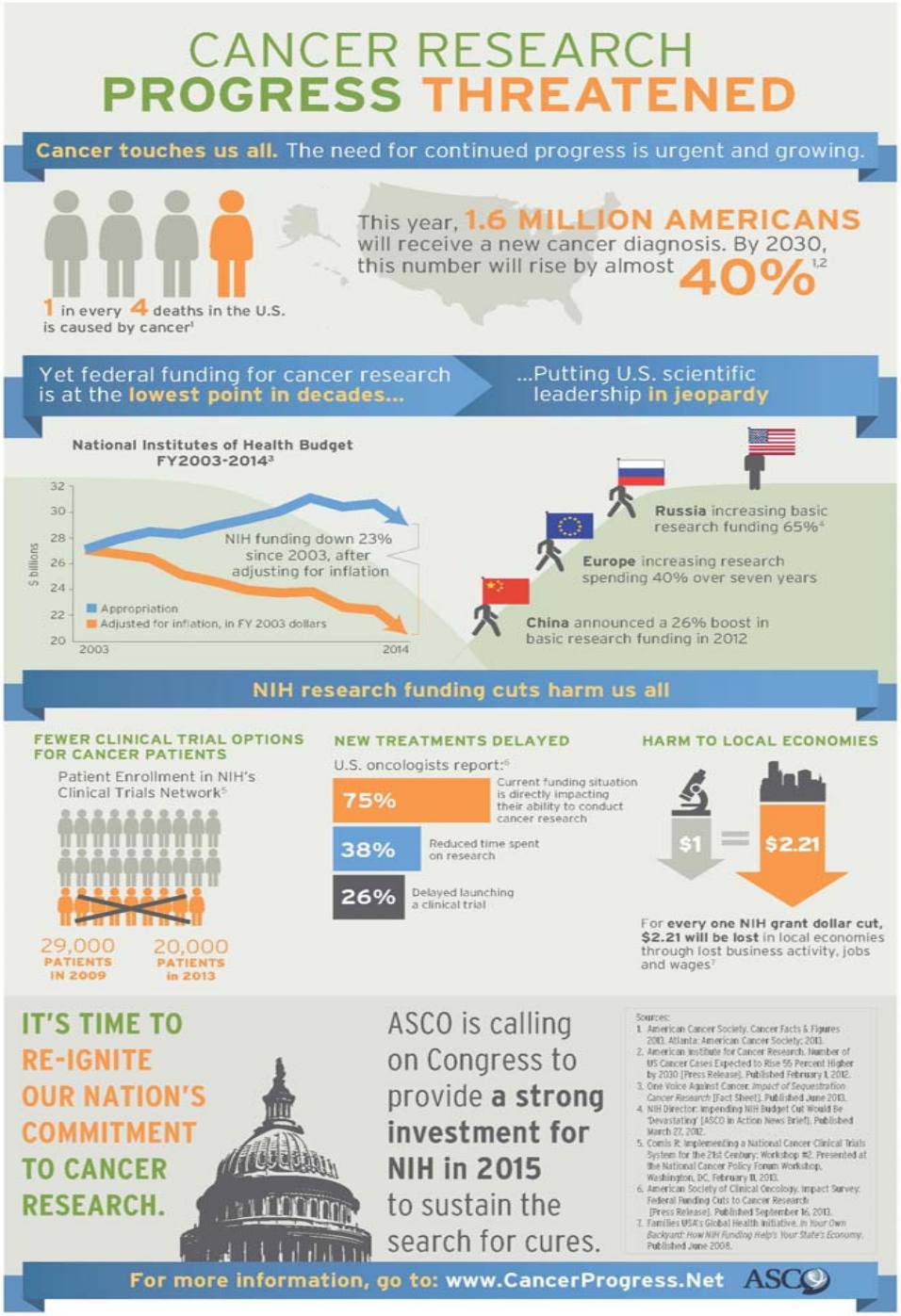

Our Message

- 2014 increases not a budget victory for medical research
- Does not go far enough
- Adjusting for inflation, NIH budget below 2013 levels

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ASCO FY15 Funding Requests

- These funding levels will keep the agencies at pace with the rate of biomedical research inflation and provide some additional increase for new projects.

NIH	NCI	FDA
$32 billion	$5.26 billion	$2.8 billion

Dedicated Website: www.asco.org/nihfunding

Federally Funded Cancer Research | ASCO.org

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ASCO American Society of Clinical Oncology

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SEARCH

Home > Advocacy > Federally Funded Cancer Research

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Federally Funded Cancer Research

Federally Funded Research

Federal funding for cancer research has remained flat for more than a decade, and when adjusted for inflation, funding has actually decreased. National Institutes of Health (NIH) Director Francis Collins, MD, recently called 2013 the "darkest ever" year for agency funding. ASCO is raising the alarm about continuing erosion of cancer research funding and urging the federal government to take bold new action to ensure the pace of progress is not stalled. Click on the headlines below to learn more.

Cancer Progress in Jeopardy: Stories From the Front Lines: *In a new series, ASCO is exploring what's happening on the front lines in the laboratory and the clinic due to the shrinking federal funding for cancer research and clinical trials.*

"What Brilliant Minds Are We Losing?"—The budget sequestration in March 2013 forced many research programs to cut staff and narrow their research topics. Here's how it impacted a breast cancer research project led by Dr. Robert Clarke, PhD, DSc, dean for research at Georgetown University Medical Center and co-director of the Breast Cancer Program at the Lombardi Comprehensive Cancer Center in Washington, DC.

Share Your Story! ASCO wants to hear your story about how the budget cuts at NIH are affecting your research. Email publicpolicy@asco.org.

Federally Funded Cancer Research Educational Series: *As part of an extensive effort to educate and mobilize its membership to call for a renewed national investment in federally funded cancer research, ASCO has developed an educational series of articles that explores the decade-long decline in federal funding for cancer research – and why this decline must be reversed.*

Federally Funded Cancer Research: The Catalyst for Progress Against Cancer

It has been over 40 years since President Richard Nixon signed the National Cancer Act into law. With this landmark legislation—and a robust federal investment in cancer research—the United States entered an era of rapid advancement in our understanding of cancer. That investment has yielded tremendous progress: more people than ever before are surviving cancer, and quality of life for those with the disease has dramatically improved.

Federally Funded Cancer Research: The Politics and Process of Medical Research Funding

The pace of progress in modern oncology care was spurred by the National Cancer Act of 1971. But, the current economic and political realities threaten the pace of progress against cancer. A sharply divided Congress and the automatic, across-the-board sequestration cuts are converging to seriously undermine our nation's continued investment in medical research.

Source: One Voice Against Cancer

http://www.asco.org/advocacy/federally-funded-cancer-research[2/18/2014 5:48:44 PM]

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4. Quality in Cancer Care

More than two decades ago, the Institute of Medicine defined quality care as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[1] In a subsequent report, "Ensuring Quality Cancer Care," the IOM further refined the definition to mean care that is delivered in a technically competent manner with strong communication, cultural sensitivity and shared decision making.[2] Advancing access to high-quality, evidence-based care is the fundamental goal of oncology and has been core to ASCO's mission since the Society first formed in 1964.

Many organizations, including ASCO, have dedicated resources to improved measurement of the quality of care that patients receive, and to improving the quality, consistency, and value of that care. Though these efforts are not new to oncology, they are taking on increased urgency in an environment of practice and payment reform. With the United States now projected to spend $320 billion on cancer care in 2020,[3,4] diverse stakeholders are seeking ways to control spending while preserving or enhancing quality. Oncology professionals play a key role in controlling the costs of cancer care, and the profession has actively engaged in a variety of efforts to manage this growing issue. Further, concern about cost is driving demand from purchasers, payers and policymakers for clear evidence of value. Performance measurement and improvement programs are necessary components for demonstrating value and, even more importantly, driving forces toward the best possible outcomes for patients facing the life-altering diagnosis of cancer.

This chapter provides insight into the current quality of oncology care, highlights a number of recent efforts to improve quality and cost effectiveness, and describes the potential for "big data" to enhance quality and value in cancer care.

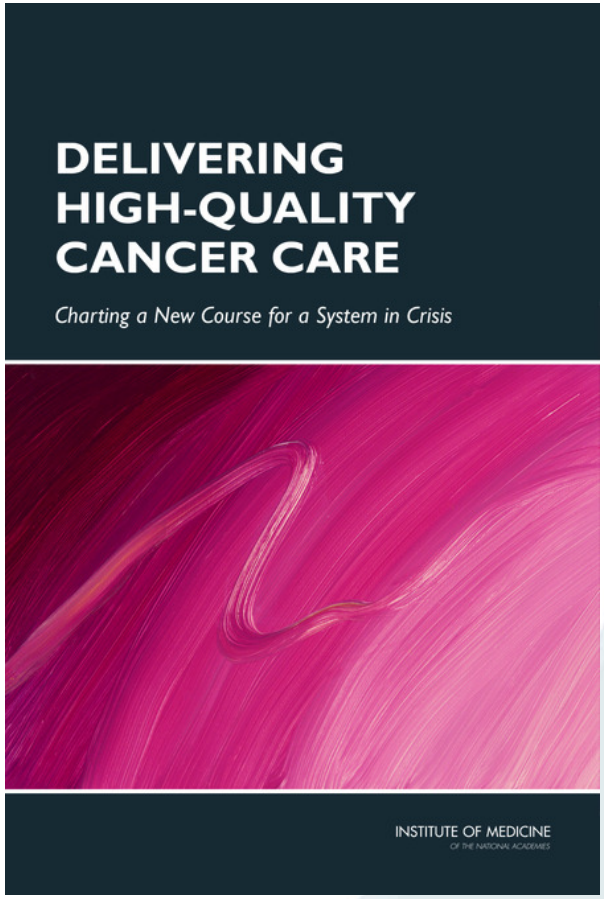
Quality Measurement: Insights from ASCO's Quality Oncology Practice Initiative

ASCO's Quality Oncology Practice Initiative (QOPI®) was launched in 2006 to promote excellence in cancer care by helping practices create a culture of self-examination and improvement. Offered as a free program to ASCO members, QOPI is an oncologist-led,

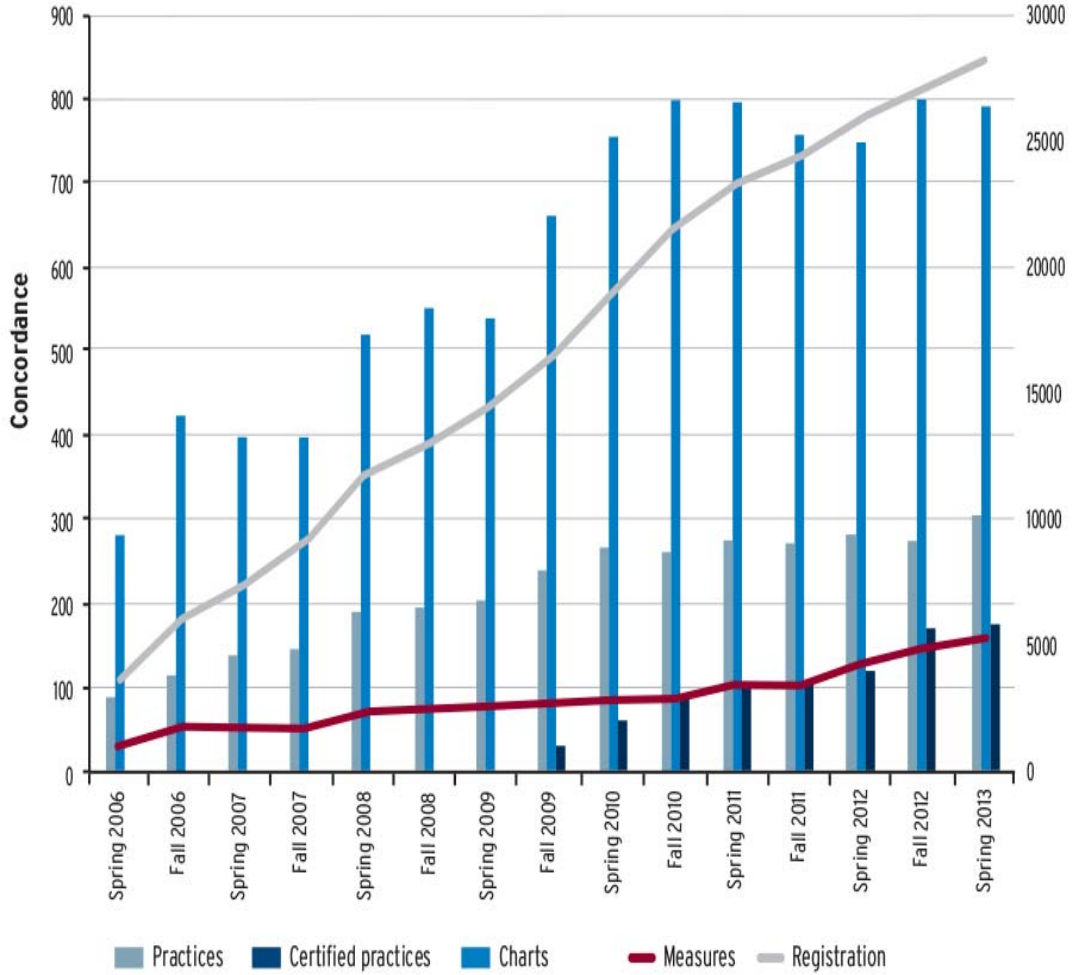
QOPI® The Quality Oncology Practice Initiative
Quality Cancer Care: Pursuing Excellence

QOPI & Certification Respond to IOM's Report on Cancer Care & Need To Measure the Quality of That Care

- End of life care consistent with patient values
- Core competencies for the workforce
- Coordinated team based care
- Communication with patients



Growth in QOPI Since 2006



The State of Cancer Care in America: 2014, American Society of Clinical Oncology.

QOPI® The Quality Oncology Practice Initiative

Quality Cancer Care: Pursuing Excellence

- Successful in engaging practices in quality assessment: In 2013, nearly 500 practices, representing 4,000 medical oncologists
- Library of nearly 200 measures
- Evolving to meet member needs
  - eQOPI (batch upload of EHR data) – 2014
  - CMS reporting (PQRS/QCDR) – data collection 2014/2015
  - Oncology Medical Home Module

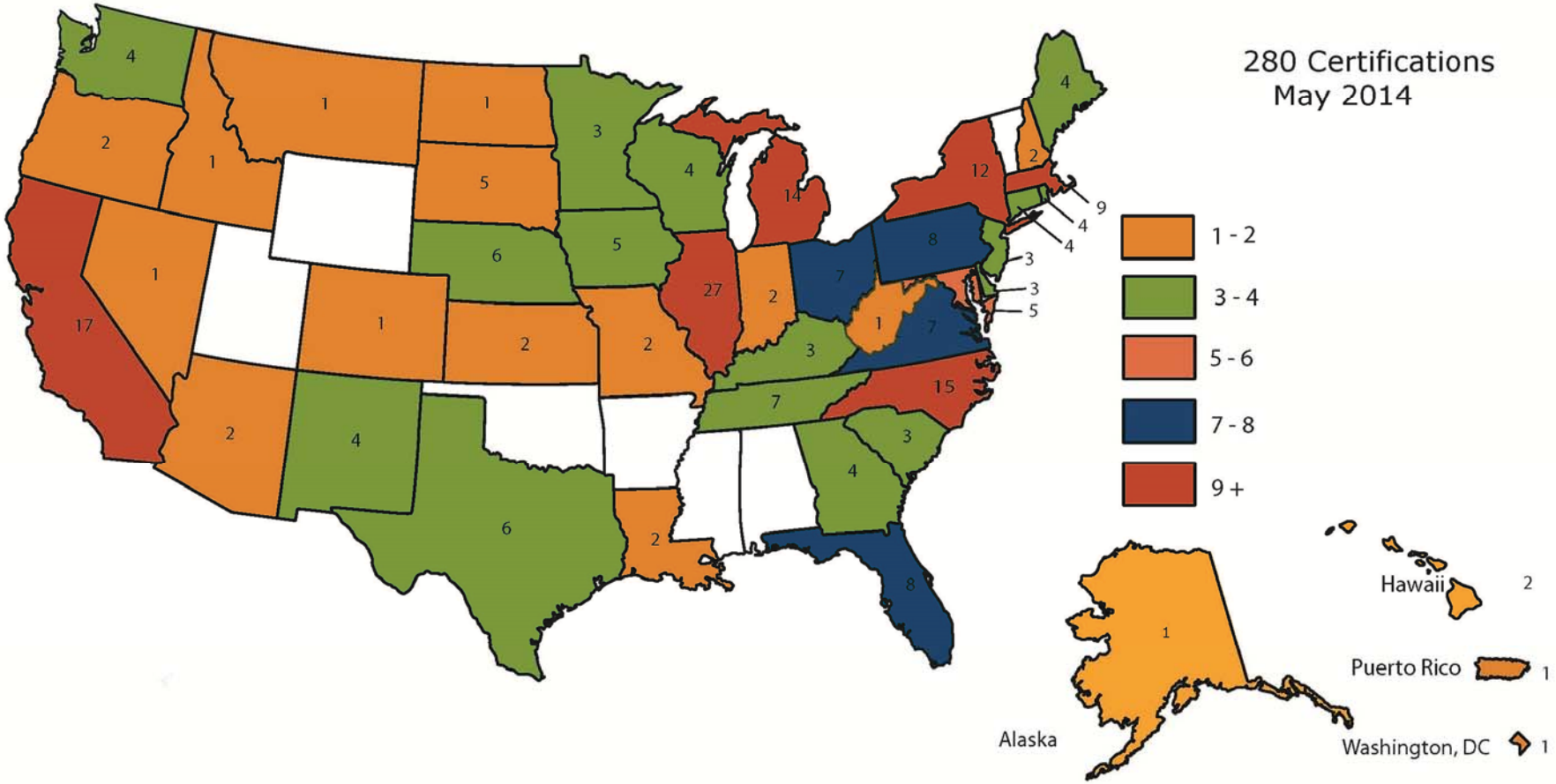
ASCO®

QOPI® as a High Value Investment

- Demonstrates adherence to evidence-based guidelines
  - Develop initiatives and interventions that will demonstrate improved clinical quality and outcomes
- Measures enhanced patient – provider communications
- Incorporates “Top 5” list to improve quality and value in cancer care
  - Identify best practices and opportunities for improvement
- Gateway to QOPI Certification

QOPI Certification Program

QOPI Certified/Recertified Practices



Certification Standards

Practices Applying For QOPI Certification Must Meet ALL 20 Certification Standards Which Are Based On The ASCO/ONS Standards For Safe Chemotherapy Administration

PRACTICE AREAS

- Staffing
- Treatment Planning & Chart Documentation
- Informed Consent
- Chemotherapy Orders
- Drug Preparation
- Chemotherapy Administration
- Patient Monitoring and Assessment
- Preparedness for emergency situations
- Oral Chemotherapy
- Patient Education

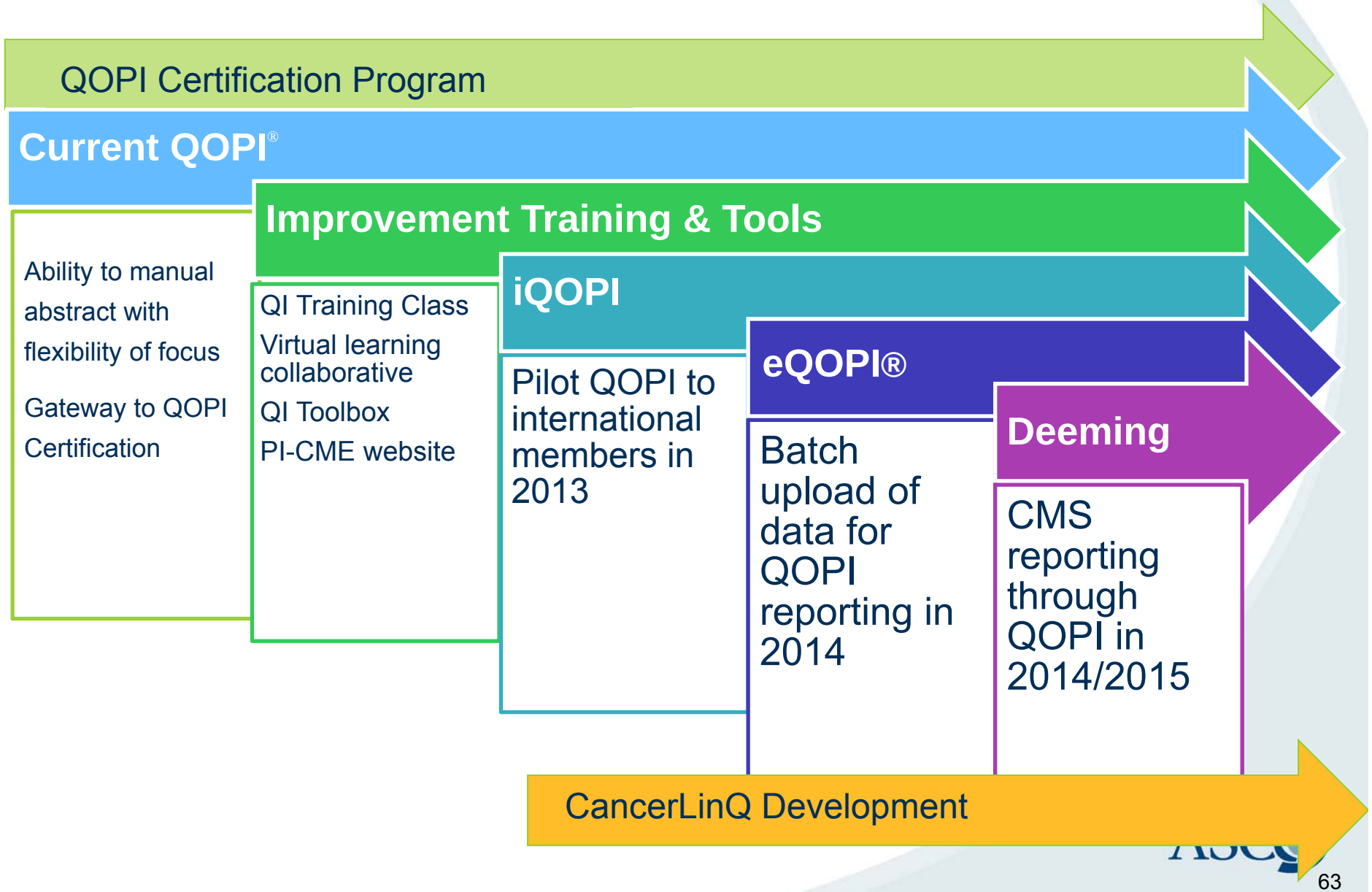
What's In It for Institutions/Practices?

- **GOLD STANDARD** for oncology care
- Aligns with many TJC standards but more oncology relevant
- Ability to market your cancer center's focus on quality & safety
- Demonstrates to payers adherence to national standards of care

Limitations

- Manual
- Retrospective
- Incomplete
- Twice annually
- Incomplete adoption
- Assesses process not outcomes

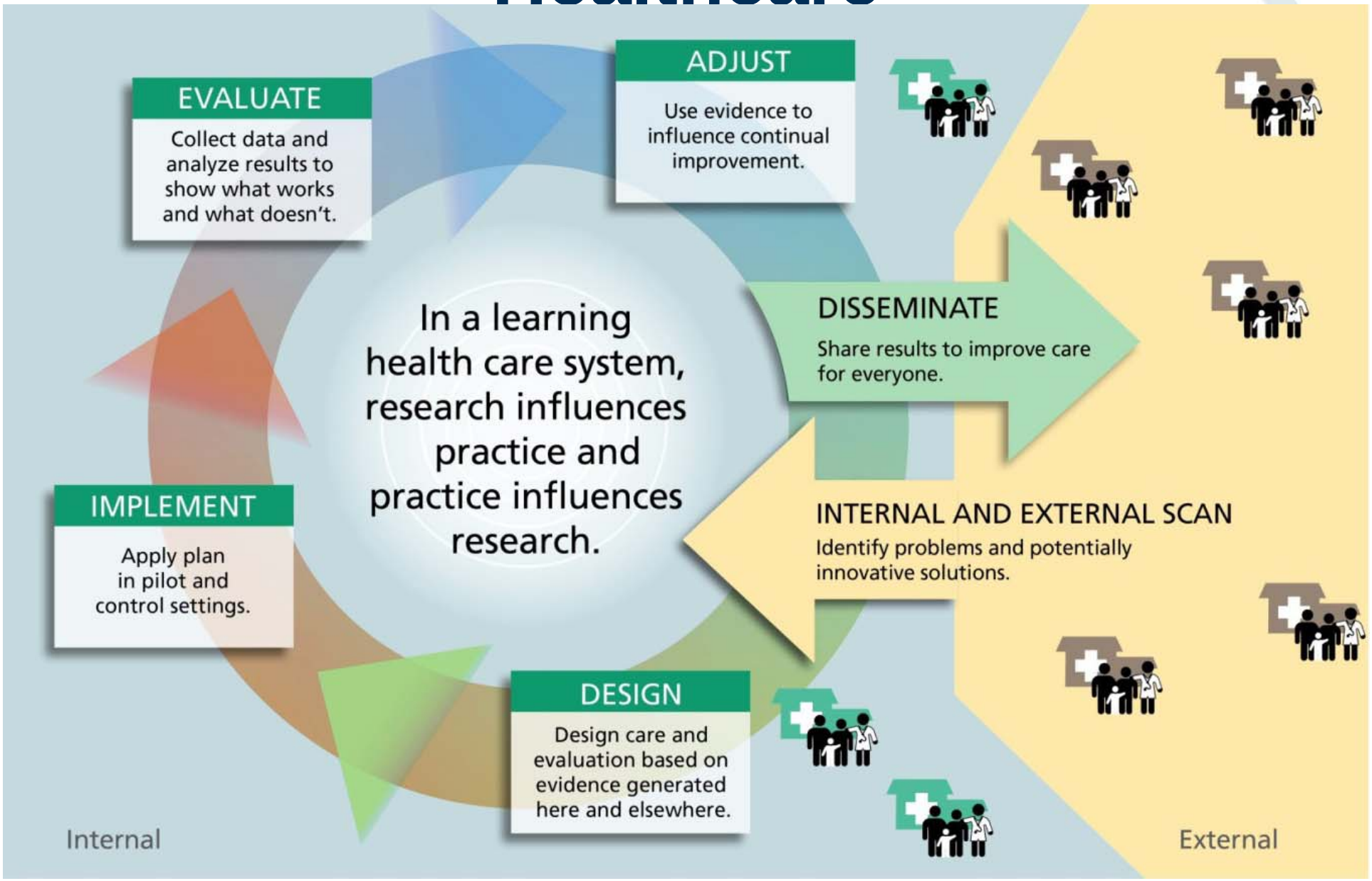
Evolution to Meet Member Needs



The Vision

A system in which real-time clinical data is captured, analyzed, and used to enhance patient care and drive scientific discovery

The Virtuous Cycle of Learning Healthcare



The treatment experience of
95% of people with cancer
is isolated in their individual medical
records.

CancerLinQ will collect data, analyze it,
create knowledge then provide real-time
access for doctors, researchers and patients.

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Improving Quality for Patients, Providers, Researchers

The primary purpose of CancerLinQ is to improve the QUALITY of care and to enhance outcomes; additional benefits include:

For Patients:

- Improved outcomes
- Clinical Trial matching
- Safety Monitoring
- Real time side effect management
- Patient Reported Outcomes

For Providers:

- Real time "second opinions"
- Observational and guideline-driven Clinical Decision Support
- Real time access to resources at the point of care
- Quality reporting and benchmarking

For Research/Public Health:

- Mining "big data" for correlations
- Comparative Effectiveness Research
- Hypothesis generating exploration of data
- Identifying early signals for adverse events and effectiveness in "off label" use

Paradigm Shift in Providing Care

TODAY'S CARE MODEL	TOMORROW'S CancerLinQ MODEL
Providers seek out content	Content comes to providers at point of care
Care is fragmented and key information is missing	Complete Longitudinal Data flows between patients and providers
Research requires years; real-world data are lacking	Learning from every patient becomes a reality; cycle of EBM is dramatically hastened

ASCO CANCER·LINQ™ Learning Intelligence Network for Quality

ASCO INSTITUTE FOR QUALITY

Paradigm Shift in Technology

ASCO CANCER·LINQ™ Learning Intelligence Network for Quality

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State Efforts Matter

- Visit with members of Congress (home or DC)
- Share your stories
- Supportive letters/messages
- Stay in touch!

We Hear You…and Feel Your Pain

- Rapid escalation in scope of issues
- Volatile practice environment
  - Economic pressures
  - Consolidations, mergers
  - Focus on value
  - Shifting care models
  - Growing administrative burden
- Practices need help

New Department of Clinical Affairs

Helping practices survive and thrive…

today AND in the future

- Physician Led
- Education, e.g.
  - Practice administration
  - How to negotiate
- Information and analysis
  - Template contracts or agreements
  - Practice trends
  - Economic analysis
- Hands on help
  - QI projects
  - Learning networks

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