ONCOLOGY MEDICAL HOME UPDATE

Bruce Gould, MD
Medical Director
OMH Steering Committee Chair
Oncology Medical Home Summary

Model
- Identify Stakeholder Needs
- Define Model Elements
- Develop Accreditation Program

Measurement
- Develop Quality/Value Measures
- Develop Patient Satisfaction Tool

Implementation
- Identify Vendors
- Categorize Tools
- Develop Practice Implementation Guide

Payment
- Identify Viable Payment Models
- Develop Private Payer Templates
- Develop Medicare Model
# OMH Steering Committee

<table>
<thead>
<tr>
<th>Oncologists</th>
<th>Payers</th>
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<tbody>
<tr>
<td>Bruce Gould, MD (GA) Chair</td>
<td>Lee Newcomer, MD United Insurance Group</td>
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<tr>
<td>Patrick Cobb, MD (MT)</td>
<td>Ira Klein, MD Aetna Insurance Company</td>
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<td>Frontier Cancer Center</td>
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<tr>
<td>Marcus Neubauer MD McKesson/US Oncology</td>
<td>Michael Fine, MD Healthnet</td>
</tr>
<tr>
<td>John Sprandio, MD (PA) Consultants in Medical Oncology</td>
<td>Dexter Shurney, MD Cummins Inc.</td>
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<tr>
<td>Administrators</td>
<td>John Fox, MD Priority Health</td>
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<td>Dayton Physician Network</td>
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<td>Cancer Care Advocates</td>
<td>Nurse</td>
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<tr>
<td>National Pt Advocacy Foundation</td>
<td>Marsha Devita, NPA (NY) Hem Onc Assoc of CNY</td>
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<td>Nancy Davenport-Ennis</td>
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<tr>
<td>ASCO</td>
<td>Pharmacist</td>
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<tr>
<td>John Cox, DO</td>
<td>Karen Kellogg, Pharm D (UT) Utah Cancer Specialists</td>
</tr>
<tr>
<td>Lynn Fitzgerald NCCN</td>
<td>Business Partner</td>
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<td>Dave Leverett Amerisource Bergen</td>
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Why the Oncology Medical Home?

- **Best Outcomes**
- **Focus is first on the stakeholders**
  - Meeting the needs of patients, payers, and providers in cancer care
- **Meeting their needs requires:**
  - Improving the patient experience
  - Providing better value for the healthcare dollar
  - Keeping expert cancer care close to the patients’ homes
- **Measures of quality and value specific to cancer care**
  - Includes patient satisfaction/experience
  - 19 measures that cover diagnosis to survivorship to death
Three Stakeholder Needs of an OMH

- Best Outcomes
- Best possible survivorship and ability to be productive
- Fewest toxicities and hospitalizations
- Safety of therapy
- Satisfied patients/members and families
Processes of care

- Best Practices – Medical Oncology, Radiation Oncology, Radiology, supportive care guidelines
  - Appropriate use of Genomics
  - Oral Compliance
- Proactive patient management
  - Structured triage
- Efficient use of resources – ER/Hospitals
- End of Life Care
OMH MEASURES

Patient Care
Resource Utilization
End of Life
Survivorship
OMH measures

PATIENT CARE

- % of patients with pathology staging pre-chemotherapy
- % of patients that receive a treatment plan pre-chemotherapy
- % of chemotherapy treatments that are adherent to NCCN guidelines
- Antiemetic appropriateness
- % of patients receiving GCSF with > 20 % risk of febrile neutropenia
- Presence of performance status before a new line of treatment
OMH Measures

RESOURCE UTILIZATION

- # of Emergency Room visits/patient/year
- # of hospital admissions/patient/year
- % of early stage breast cancer patients that received advanced diagnostic imaging
- % of early stage prostate cancer patients that receive advanced diagnostic imaging
OMH Measures

END of LIFE

- % of Stage IV patients with end of life discussions documented
- Average # of days in hospice
- # of deaths in the acute care setting
- Days from last chemotherapy until date of death
OMH Measures

SURVIVORSHIP

• % of patients receiving a survivorship plan < 45 days post chemotherapy
• % of patients receiving psycho/social screening and interventions
• Survival rate of colon, lung, breast cancer patients - all stages
Medical Home Projects

- **Come Home CMS demonstration project**
  - 7 practice demo including NGOC
- **Aetna OMH pilot**
- **Priority Health OMH in Michigan**
- **Single Practice Demos**
  - Linda Bosserman, M.D. and Wellpoint
  - John Sprandio, M.D. and Aetna
- **Others**
Key Attributes of the OMH

- The clinical team “quarterbacks” the patient care which leads to an enhanced patient experience

- Provides the payers better value for their Healthcare dollar

- Aligns financial incentives so that community oncology practices can stay independent and expert cancer care can remain close to home
Oncology Medical Home Pilot Update
Daniel P. McKellar, MD, FACS
Chair, Commission on Cancer
Oncology Medical Home Accreditation Pilot Project Update

Why the COC?

➢ 80 years of experience accrediting cancer programs
  • Comprehensive Patient-Centered standards
  • Leader in quality metric development and implementation

➢ Significant infrastructure in place
  • Well trained knowledgeable staff
  • Trained and experienced surveyor team
  • Experience with data on cancer patients (NCDB)
  • Numerous educational programs for cancer programs

➢ National recognition for accrediting cancer programs

➢ 52 professional organization representatives
Commission on Cancer: Our Mission

The CoC is a consortium of professional organizations dedicated to improving survival and quality of life for cancer patients through standard-setting, prevention, research, education, and the monitoring of comprehensive quality care.
Oncology Medical Home Accreditation Pilot Project Update

Progress to date…

- Workgroup established and meets by conference call
  - Commission on Cancer (COC)
  - Community Oncology Alliance (COA)
  - American Society of Clinical Oncology (ASCO)
  - National Comprehensive Cancer Network (NCCN)
- Outline of standards developed
- CMMI Grant application submitted
Oncology Medical Home Accreditation Pilot Project Update

Proposed Standards

- Eligibility Criteria Similar to Commission on Cancer criteria

- 5 Domains of Care
  - Patient Engagement
  - Expanded Access
  - Evidence Based Medicine
  - Comprehensive Team Based Care
  - Quality Improvement
## Domain 1: Patient Engagement

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- Documented policy on communication standards of the practice to ensure timely and comprehensive communications with patients/caregivers.
- Policy and procedure and education materials provided to patients and caregivers prior to chemotherapy.
- Documented policy and procedure on a patient call-back policy; include adherence rates (Time Received Call/Time Returned Call).

### 1.3 Patient portal available or under development

- If portal is under development, a provided implementation plan.
- If portal is active:
  - Demonstrated access to a patient portal.
  - Documentation of usage statistic of patient portal.

*COMMENDATION STANDARD:* Patient portal is available for communications with care team.

| Objective Validation | • % of patients receiving treatment plan prior to initiation of chemotherapy |
## Domain 2: Expanded Access

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### 2.2 Documented evidence of Access for Established Patients
- Documented evidence of new patient scheduling procedure that reflects triage process and provider requests.
- Documented evidence of same day appointments each month.
- Documented evidence of patients using triage system per month.
- Documentation of expanded after hours availability.
- Documentation on the triage process for the practice.

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## 3.2 Clinical Trials Access

- Documented policy and procedure for how patients are offered clinical trials.
- Documented clinical trial accrual log, if accrued within the practice.
- Documentation of patients referred out of the practice for clinical trials.

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### Domain 4: Comprehensive Team Based Care

#### Process Validation

**4.1 Care Coordination**
- Documented policies and procedures for communicating with referring physicians and PCPs, palliative care/symptom management and hospice teams.
- Documented policies and procedures of communication flow between the patient’s care teams within the oncology practice. (eg. pharmacist, social worker, nurses, schedulers, financial counselors, dietician, etc.)
- Random chart audits for documented communications to referring physicians and PCPs.
- Random chart audits for documented communication flow within the practice.
- Documented policies and procedures for referral/scheduling to specialties/services listed in the Domain.
- Documented policies and procedures to track/audit appointments to test results and demonstrated management of these processes.
- Documented policies and procedures of psycho/social screenings and interventions.
- Documented policies and procedures for providing a treatment summary and survivorship care plans.

**4.2 Referral Adherence**
- Documented policy and procedure for following up on open referrals.

#### Objective Validation

- % of Stage IV patients with advanced care plan discussions documented.
- Average number of days on hospice at time of death.
- % of patients receiving at least one psychosocial distress screening.
- % of patients receiving a survivorship plan within 30 days of completion of treatment.
## Domain 5: Quality Improvement

### Documentation or Process Validation

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<td>• Demonstrated use of reporting/benchmarks of OMH Patient Satisfaction Survey.</td>
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### Quality Improvement Processes

- Documented practice/center policy and procedure for continuous quality improvement.
- Optional demonstrated use of reporting/benchmarking within QOPI.
- OR internal quarterly quality review audits) with associated clinical improvement activities.
- OR demonstrated use of Meaningful Use to further quality improvement.
- OR any combination above.
- Demonstrated use of Commission on Cancer reporting/benchmarking based.

### Objective Validation

- Survival rates for breast, colon and non small cell lung cancer, by stage.
- Chemotherapy given within 30 days of end of life.
- % of patients who die in acute care setting.
Oncology Medical Home Accreditation Pilot Project Update

Next Steps…

- Finalize standards and compliance measures
- Develop standards manual
- Education to practices on standards and requirements to meet standards
- Develop a database for practices to report measure and standard compliance
- Develop resources to assist practices in meeting standards
  - Best practices
  - Educational Programs such as webinars
ONCOLOGY MEDICAL HOME
OMH IMPLEMENTATION TEAM

Carol Murtaugh, RN, OCN,
Practice Administrator
OMH Implementation Chair
OMH Implementation Team

- 8 Oncology Practice Administrators

- Web site collection of resources for all stakeholders: providers, payers, and patients
  - Over 50 tools, technologies, and templates

www.medicalhomeoncology.org
OMH Implementation Team

- **Patient Resources**
  - “My Directives” web based program
  - NCCN disease specific information guides

- **Payer Resources**
  - NAMCP Medical Directors Guide: Oncology
  - Registration to view practice survey results

- **Provider Resources**
  - Pathway Management Tools
  - Survivorship and Psycho/Social Distress Screening Tools
OMH Implementation Team

- CAHPS Based Oncology Patient Satisfaction Survey
  - Electronic or Paper
  - Over 17,000 benchmarked surveys
  - 1,092 providers
  - 2,400 sites of care
Patient Satisfaction Survey
Benchmarking within practice
Patient Satisfaction Survey

Benchmarking to other practices
OMH Implementation Team

- **Provider Resources (Cont’d)**
  (Tools to help with accreditation in development)
  - Policies Templates
  - Procedure and Process information

- **Champions Program**
  - Industry partners
  - Provide tools and support
Purpose – To develop and promote the intermediate and long term definitions to submit (electronically) quality, value and outcomes data to support the Oncology Medical Home accreditation program.
## IT Advisory Team Representation

<table>
<thead>
<tr>
<th>Industry Representation</th>
<th>Practice Representation</th>
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<tbody>
<tr>
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<td>Florida</td>
</tr>
<tr>
<td>COA</td>
<td>Georgia</td>
</tr>
<tr>
<td>CoC</td>
<td>Ohio</td>
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<tr>
<td>COME HOME</td>
<td>Texas</td>
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IT Advisory Team

- **Effort to date**
  - 2 team calls
  - Participants studying ratios and data points

- **Goals/Targets**
  - Automatic aggregate data submission by Q4 2014.
  - Automatic accreditation registry data submission by Q2 2015.
ONCOLOGY MEDICAL HOME
PAYMENT REFORM

Gordon Kuntz, ION Solutions
Community Oncology Conference
Friday, April 4, 2014
Oncology Payment Reform

IS HERE!
All Shapes and Sizes

- Pay for pathways
- Pay for new services
- Pay for reporting
- Pay for performance
- Shared savings
- Bundling
- Rewarding patients
Consistent Message From Payers

- Focus on the patient
- Patient “satisfaction”
- Measurable and applicable performance
  - Demonstrated Quality & VALUE
- Preservation of community cancer care
- Comprehensive and team based care
- Best clinical outcomes
Come Home - CMMI Demonstration Project

- The ONLY approved oncology project approved in Phase I CMMI
- Led by Barbara McAneny M.D., New Mexico Cancer Center
- 7 practices in 6 states
- 3 year project that started October 2012
- 7 diseases
- University of Tennessee is leading the healthcare economic analysis and validating the data analysis
COME HOME (Medicare) Project
Aetna Medical Home Pilot

- Initially 3 practices
- Breast, Lung, Colon/Rectal
- Via Oncology Pathways
- Increased Generic Drug Fees
- Management Fees
  - Initial treatment plan,
  - End of treatment summary
  - Advanced care planning
  - Oral Oncolytics
- 30% Shared Savings vs. Region (12 month reconciliation)
All Reform Projects
(At least all that we are aware of)

Single Projects
Multiple Projects

Includes
COME HOME
Aetna OMH
Aetna practice pilots
Pathway Projects
Priority Health
Satisfaction Reporting
Other
Oncology Payment Reform

How to prepare

- Understand your own quality and value proposition
- Engage your entire team
- Educate your local payers
- Educate your local large employers
- Negotiate based on quality and value
- Renegotiate based on quality and value
- Look for quality add-ons
Stakeholder Driven
ONCOLOGY MEDICAL HOME

A process for all stakeholders

Questions for the Panel
Eligibility Criteria

- Practice is using a certified EHR
- Practice leadership, including administrators and physician is supportive of the medical home concept, willing to change practice policies and procedures to achieve accreditation.
- Practice has oriented their entire staff/cancer care team on the importance and significance of OMH concepts. (CoC/COA is available to assist with this communication as needed.)
- Practice is willing to maintain patient level data at the practice and to share aggregate data with the CoC, the accrediting body, on a monthly or quarterly basis for measurement purposes. The practice may elect to retain a data aggregator such as NDO or Flatiron to assist with this effort.
- Practice is administering the COA patient satisfaction survey every 3-6 months
# Domain 1: Patient Engagement

## Infrastructure
- 1. Financial Counselors are in place to meet the patients’ needs.
- 3. Practice has access to a Patient Portal.

## Process Standards

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<td><strong>1.1A</strong> Financial counselor available to all patients.</td>
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<tr>
<td><strong>1.1B</strong> Financial assistance programs are communicated to patients.</td>
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<tr>
<td><strong>1.1C</strong> Medication assistance programs are available.</td>
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<table>
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<th>1.2 Patient Orientation, Education and Communication</th>
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<td><strong>1.2A</strong> New patient/caregiver orientation to practice and responsibilities.</td>
</tr>
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<td><strong>1.2B</strong> Education of patients/caregivers prior to receiving chemotherapy.</td>
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<tr>
<th>1.3 Patient portal available or under development</th>
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<td><strong>1.3A</strong> Patient has online access to treatment guides and other tools to understand and manage their disease.</td>
</tr>
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<td><strong>1.3B</strong> Patient has online access to their treatment plans and test results.</td>
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| Objective Validation | • % of patients receiving treatment plan prior to initiation of chemotherapy |
# Domain 2: Expanded Access

## Infrastructure

2. Urgent and emergency patient access for established patients.
5. Direct Admissions (bypassing ED when medically appropriate).

## Process Standards

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<tr>
<th>Section</th>
<th>Details</th>
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<tbody>
<tr>
<td><strong>2.1</strong> New Patients</td>
<td><strong>2.1A</strong> Triage process for new patient referrals. <strong>2.1B</strong> Urgent appointments available for new patients as requested or medically required.</td>
</tr>
<tr>
<td><strong>2.2</strong> Patients on Active Treatment/Established Patients</td>
<td><strong>2.2A</strong> Same day appointments offered as a routine/standard part of Practice's scheduling processes. <strong>2.2B</strong> Walk-in appointments offered as a routine/standard part of Practice's scheduling processes. <strong>2.2C</strong> After hours availability to manage patient issues (i.e.: weekend infusions, injections, extended practice hours, on-call physician access, etc.). <strong>2.2D</strong> Triage system in place to support active symptom management of patients.</td>
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# Domain 2: Expanded Access

## Documentation or Process Validation

### 2.1 New Patient Access

- Policy and procedure that outlines all aspects of expanded access, including: expedited appointments for new patients, urgent and emergent appointments for established patients, and same-day/walk-in appointments for patients under treatment.

### 2.2 Documented evidence of Access for Established Patients

- Documented evidence of new patient scheduling procedure that reflects triage process and provider requests.
- Documented evidence of same day appointments each month.
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## Objective Validation

- Number of emergency room visits per chemotherapy patient per year to validate outcomes of effective triage and expanded access.
- Number of hospital admissions per chemotherapy patient per year to validate outcomes of effective triage and expanded access.
- Patient satisfaction scores related to expanded access.
# Domain 3: Evidenced Based Medicine

| Infrastructure | 1. Treatment Guidelines used (ex. NCCN, ASCO, COME HOME, VIA).  
2. Clinical Trials are offered (on site or by referral). |
|----------------|-----------------------------------------------------------------|
| Process Standards | **3.1 Evidence-Based Practice**  
3.1A. Practice utilizes scientifically validated evidence-based guidelines (eg. NCCN/ASCO/COME HOME/VIA).  
3.1B. Process for safe medication administration according to scientifically validated evidence-based guidelines (eg. ONS/ASCO).  
3.1C. Appropriate utilization of resources (eg. laboratory and imaging studies)  
**3.2 Clinical Trials Access**  
3.2A Process to refer patients and/or enroll patients in clinical trials. |
## Domain 3: Evidenced Based Medicine

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# Domain 4: Care Coordination

## Infrastructure

1. Practice has established relationships with outside providers for management of non-cancer symptoms.
2. Inpatient team-based care in which oncologist co-manages the patient with hospitalists and/or primary care physicians.
3. Physician-directed outpatient team-based care within the oncology practice.
4. Practice delivers or refers for the diagnosis, treatment of cancer and management of comorbid conditions and side effects.

## Process Standards

### 4.1 Care Coordination

4.1A Care coordination with PCP.
4.1B Care coordination with hospice.
4.1C Practice has established communication processes to keep other providers informed of patient’s treatment plan and current status.
4.1D Practice provides the following or has process(es) for referral or scheduling:
   - Surgery
   - Rehabilitation
   - Nutritional Support/counseling
   - Radiation Therapy
   - Diagnostic Imaging
   - Laboratory Studies
   - Psychosocial Evaluation and Support
   - Financial Counseling
   - Genetic Counseling
   - Survivorship Care Planning and Treatment Summaries
   - Palliative Care/Symptom Management

### 4.2 Referral Adherence:

4.2A Practice has process(es) to ensure patient follow through on testing, referrals and future appointments.
## Domain 4: Comprehensive Team Based Care

<table>
<thead>
<tr>
<th>Process Validation</th>
<th>Objective Validation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4.1 Care Coordination</strong></td>
<td><strong>% of Stage IV patients with advanced care plan discussions documented.</strong></td>
</tr>
<tr>
<td>• Documented policies and procedures for communicating with referring physicians and PCPs, palliative care/symptom management and hospice teams.</td>
<td>• Average number of days on hospice at time of death.</td>
</tr>
<tr>
<td>• Documented policies and procedures of communication flow between the patient’s care teams within the oncology practice. (e.g. pharmacist, social worker, nurses, schedulers, financial counselors, dietician, etc.)</td>
<td>• % of patients receiving at least one psychosocial distress screening.</td>
</tr>
<tr>
<td>• Random chart audits for documented communications to referring physicians and PCPs.</td>
<td>• % of patients receiving a survivorship plan within 30 days of completion of treatment.</td>
</tr>
<tr>
<td>• Random chart audits for documented communication flow within the practice.</td>
<td></td>
</tr>
</tbody>
</table>
# Domain 5: Quality Improvement

## Infrastructure
1. Certified EHR.
2. Practice has implemented documentation standards.
3. OMH Patient Satisfaction Survey.

## Process Standards

<table>
<thead>
<tr>
<th>5.1 Patient Satisfaction Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1A Patient satisfaction surveys reviewed by practice.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5.2 Quality Improvement Processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.2A Established quality improvement process in place (eg. Participation in QOPI, internal quarterly quality review audits) with associated clinical improvement activities.</td>
</tr>
</tbody>
</table>

| 5.3 Practice submits data annually to the OMH database and monitors compliance with mandatory measures. |
### Domain 5: Quality Improvement

#### Documentation or Process Validation

<table>
<thead>
<tr>
<th>5.1 Patient Satisfaction Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Demonstrated use of reporting/benchmarking of OMH Patient Satisfaction Survey.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5.2 Quality Improvement Processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Documented practice/center policy and procedure for continuous quality improvement.</td>
</tr>
<tr>
<td>• Optional demonstrated use of reporting/benchmarking within QOPI.</td>
</tr>
<tr>
<td>• <strong>OR</strong> internal quarterly quality review audits) with associated clinical improvement activities.</td>
</tr>
<tr>
<td>• <strong>OR</strong> demonstrated use of Meaningful Use to further quality improvement.</td>
</tr>
<tr>
<td>• <strong>OR</strong> any combination above.</td>
</tr>
<tr>
<td>• Demonstrated use of Commission on Cancer reporting/benchmarking based.</td>
</tr>
</tbody>
</table>

#### Objective Validation

<table>
<thead>
<tr>
<th>5.3 Practice submits data and monitors compliance with mandatory measures as established by Commission on Cancer.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Survival rates for breast, colon and non small cell lung cancer, by stage.</td>
</tr>
<tr>
<td>• Chemotherapy given within 30 days of end of life.</td>
</tr>
<tr>
<td>• % of patients who die in acute care setting.</td>
</tr>
</tbody>
</table>