The Commission on Cancer: Past, Present, and Future

Allison C. Knutson, CCRP
Manager of Accreditation & Standards
Commission on Cancer
Chicago, IL
Presentation Objectives

√ Discuss the updates to the Commission on Cancer (CoC)’s Eligibility Requirements and Standards.

√ Describe how the standards can be used to develop cancer programs that offer a comprehensive, patient-centered, multidisciplinary approach to care.

√ Recognize the value of accreditation and the importance of cancer programs providing patient-centered care and various oncology supportive care and clinical services.

√ State the future endeavors and initiatives of the CoC.
Our Mission

The Commission on Cancer 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.
CoC’s Objectives

- **Establish standards** to ensure quality, multidisciplinary, and comprehensive cancer care delivery in healthcare settings
- Conduct surveys in healthcare settings to assess compliance with those standards
- Collect and use data to monitor treatment patterns and outcomes and enhance cancer control and clinical surveillance activities
- Provide access to data for cancer programs to use for quality improvement, administrative purposes, and for research
- Provide **resources and effective educational interventions** to cancer programs to **improve cancer prevention, early detection, care delivery, and outcomes.**
Leading Change

1. Create Urgency
2. Form a powerful coalition
3. Create a vision for change
4. Communicate the vision
5. Remove obstacles
6. Create short-term wins
7. Build on the change
8. Anchor the changes

CoC Standards

- The Accreditation Survey
- The Cancer Committee
- Cancer program goals
- Cancer committee meetings
- Quality studies and improvements
- Accomplishing goals and completing improvements
- Annual (continuous) goals, studies, and improvements
Commission on Cancer Initiatives

New and Revised Standards

– Patient-centered
– Address the full continuum of cancer care
– Strong focus on quality and improvement

Improved Resources for Cancer Programs

– Improved NCDB data tools and reports
– Improved website
– Best Practices and updates to the Standard Resource Library
– Educational workshops and webinars
Requirements are more specific to eliminate ambiguity and improve reporting of outcomes.

All standard definitions and requirements were effective January 1, 2016 with the first programs to be rated on these requirements will be surveyed in 2017.
Fundamental Principles of Requirements

Sample of language change: ER11 Rehabilitation Services

2012: “A policy or procedure is in place to access rehabilitation services either on-site or by referral.”

2016: Policies and procedures are in place to ensure patient access to rehabilitation services either on-site or by referral.

Time frame clarification: ‘each year’ replaced with ‘each calendar year’ to establish the defined quarters and years in which compliance is expected.

Emphasis on the decision making authority of the cancer committee and the role of the coordinators and designees.
Eligibility Requirements (ER1 – ER12)

Program Structure
- Facility Accreditation
- Cancer Committee Authority
- Cancer Conference Policy
- Oncology Nursing Leadership
- Cancer Registry Policy and Procedure

Program Services
- Diagnostic Imaging Services
- Radiation Oncology Services
- Systemic Therapy Services*
- Clinical Research Information*
- Psychosocial Support Services
- Rehabilitation Services*
- Nutritional Services*

* = Clarifications to requirements
"The program provides a copy of the facility-wide or cancer program policy or procedure that ensures access to rehabilitation services and identifies the rehabilitative services that are provided either on-site or by referral."

"Each calendar year, the program uploads a copy of the most recent facility-wide or cancer program policies and procedures that ensures access to rehabilitation services either on-site or by referral, and includes annual monitoring of the referral process."
Comprehensive oncology rehabilitation programs support Eligibility Requirement 11, AND…

✓ Improve survivors’ quality of life
✓ Improve patient outcomes,
✓ Lead to increased patient satisfaction scores
✓ Assist in the development of survivorship care plans that include post-treatment rehabilitation (Std 3.3)
✓ Provide a reimbursable service line.
Cancer Rehabilitation Across the Cancer Care Continuum

- Prevention and Screening
- Diagnosis
- Treatment
- Survivorship
- End of Life Care

(PRE) REHABILITATION SCREENING AND SERVICES
ER-11: Rehabilitation Services - Complete

Policies and procedures are in place to ensure patient access to rehabilitation services either on-site or by referral. This resources and services information will be displayed in the "Find an Accredited Program".

### Summary of Rehabilitation Services Provided

<table>
<thead>
<tr>
<th>Services</th>
<th>Facility</th>
<th>Referred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise Therapy</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Lymphedema Program</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prosthetic Services</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Speech and language pathology</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Stomal Services/Wound Care Therapy</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

### Additional Rehabilitation Services

Enter additional rehabilitation services provided:

<table>
<thead>
<tr>
<th>Services</th>
<th>Facility</th>
<th>Referred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex Decongestive Therapy</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

### Documentation

Each calendar year, the program uploads a copy of the most recent facility-wide or cancer program post-surgery services either on-site or by referral, and includes annual monitoring of the referral process.

**Submission Date**

<table>
<thead>
<tr>
<th>09/28/2012</th>
<th>Original File Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Assessments.doc</td>
</tr>
<tr>
<td>09/28/2012</td>
<td>Rehabilitative Services Department.doc</td>
</tr>
</tbody>
</table>
Available Services

Diagnostic Imaging
Radiation Oncology Services
Systemic Therapy Services
Clinical Trial Information
Psychosocial and Supportive Services
Support Groups

Rehabilitation Services

Rehabilitation Services

Lymphedema Program
Exercise Therapy
Prosthetic Services
Speech and language pathology
Stomal Services/Wound Care Therapy
Occupational Therapy
Physical Therapy
Potential New Standards

Rehabilitation Services – ER to Standard
Nutrition Services – ER to Standard
Data Completeness
Synoptic Report for Radiology
Meeting the New Standards to Ensure Patient-Centered Care

Arnold Baskies, MD, FACS
Commission on Cancer Surveyor
Surgical Oncologist, Virtua Health Systems

Vice Chairman of the Board of Directors
American Cancer Society
Presentation Objectives

✓ What CoC Surveyors are looking for – best practices for accreditation or re-accreditation around E11 (cancer rehab) and survivorship and supportive care services.

✓ An oncology practitioner’s perspective on Value Based Care – the short and long-term adjustments oncology practices are making in preparation for new reimbursement models of care.
Accreditation makes a difference: Four key principles to measurably improve quality of care and increase value

CoC Standards
- Backed by research
- Individualized by patient population

Build the Right Infrastructure
- Staffing levels
- Specialists
- Cancer program
- Checklists

Use the Right Data
- From medical charts
- Backed by research
- Quality improvement
- NCDB tools

Verification and Accreditation
- External peer review
- Creates public assurance
Health Care in Flux

Patient-centered care is not well implemented

Systems can be complex and fragmented

Patients excluded from the care team and decision making

Too much unwanted or unneeded care

Crisis

Crossing the Quality Chasm: A New Health System for the 21st Century
Institute of Medicine (IOM)
The Current Health Care “Landscape”

- New law/regulatory pressures
- Quality and accountability pressures
- Demand for transparency
The Current Health Care “Landscape”

- New law/regulatory pressures
- Quality and accountability pressures
- Demand for transparency
- Financial pressures
- Uncertainty

Structure
Process
Fee-for-service

Patient-centered
Outcomes focused
Value-based care
CoC Standards = Patient-Centered Care

HEALTH LITERATE, ACTIVATED PATIENT & FAMILY

PRIMARY CARE

CANCER PREVENTION ➔ CANCER SCREENING ➔ DIAGNOSIS ➔ CANCER TREATMENT ➔ RECOVERY/SURVIVORSHIP ➔ END-OF-LIFE CARE

PSYCHOSOCIAL & PALLIATIVE CARE

TARGETED NAVIGATION BASED ON NEED

DISTRESS SCREENING

© American College of Surgeons 2016—Content cannot be reproduced or repurposed without written permission of the American College of Surgeons.
### Patient-Centered Barriers

<table>
<thead>
<tr>
<th>Cost</th>
<th>Social support</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance coverage</td>
<td>Comorbidities</td>
<td>Time off work</td>
</tr>
<tr>
<td>Transportation</td>
<td>Childcare</td>
<td>Too busy</td>
</tr>
<tr>
<td>Language</td>
<td>Travel time</td>
<td>Fear</td>
</tr>
<tr>
<td>Literacy</td>
<td>Housing</td>
<td>Perceptions &amp; beliefs</td>
</tr>
<tr>
<td>Disability</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Provider-Centered Barriers

- Perceptions
- Time constraints
- Provider communication
- Lack of familiarity or trust
- Adequate supply of clinicians
- Clinician gender or ethnicity
- Clinician attitudes

### Health System Barriers

- Fragmented medical system
- Missed appointments
- Lost results
- Scheduling
- Hours of operation
- Clinic neighborhood
Patient-Centered Care: IOM Recommended Solutions

• System focused on patient needs:
  – Cultural traditions and personal preferences/ values
  – Family and lifestyle situations

• Patients collaborate with healthcare team to make decisions.

• Increase roles in self-care & monitoring, provide tools and support

• Seamless transition between providers and healthcare settings
Identify Resources and Resource Gaps

- Cancer Information
- Legal
- Financial Navigation
- Survivorship
- Rehabilitation
- Supportive Care
- Transportation
- Translation Services
- Housing
CoC’s Response to IOM Report…

…DEVELOP PATIENT-FOCUSED STANDARDS

– Genetic assessment and counseling
– Palliative care services
– Patient navigation
– Psychosocial distress screening
– Survivorship care plan

How can rehabilitation play a part?
Standard 2.4 Palliative Care Services

“Palliative care services are available to patients either on-site or by referral.”
Why Palliative Care?

45-90% of pain and non-pain symptoms remain untreated in all phases of treatment.

Cancer patients are frequently poly-symptomatic and many times these do not get addressed.

Multiple studies have demonstrated benefits of palliative care in reducing pain and symptom burden and improving patient and family satisfaction with care.


3 www.capc.org/research-and-for-palliative-care/citations
Palliative Care and Rehabilitation

Rehabilitation and palliative care are two important parts of comprehensive cancer care for patients, especially advanced disease.

Both disciplines have a multidisciplinary care model, which aims to improve patients' levels of function and comfort.

Physical function and independence should be maintained as long as possible to improve patients' quality of life and reduce the burden of care for the caregivers.

Standard 3.2 Psychosocial Distress Screening

“The cancer committee develops and implements a process to integrate and monitor on-site psychosocial distress screening and referral for provision of psychosocial care.”
Reporting Psychosocial Distress

patients are not likely to initiate a conversation with the physician about distress

physician’s often defer to the patients to raise any concerns about distress-related topics

I want my doctor to pay attention to my cancer treatment

If the stress of this is too much they will tell me

I’m not crazy.

My clinic time is so limited...
**NCCN Distress Thermometer for Patients**

**Screening Tools for Measuring Distress**

Instructions: First please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.

<table>
<thead>
<tr>
<th>Extreme distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
</tr>
<tr>
<td>9</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

No distress

Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Practical Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Child care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Housing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Insurance/financial</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Transportation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Work/school</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Treatment decisions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Physical Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Appearance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bathing/dressing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Breathing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Changes in urination</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Constipation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diarrhea</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eating</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fatigue</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Feeling Swollen</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fevers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Getting around</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Indigestion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Memory/concentration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mouth sores</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nausea</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nose dry/congested</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sexual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Skin dry/itchy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sleep</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Substance abuse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tingling in hands/feet</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Other Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Family Problems**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Dealing with children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Dealing with partner</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ability to have children</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family health issues</td>
</tr>
</tbody>
</table>

**Emotional Problems**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Fears</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nervousness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sadness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Worry</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Loss of interest in usual activities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Spiritual/religious concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Psychosocial Distress Screening Components

• **Timing**- At least once per patient at a pivotal medical visit

• **Method**- Questionnaire, physician administered questionnaire, or other method

• **Tools**- Prefer standardized, validated instruments with established clinical cutoffs

• **Assessment and Referral**

• **Documentation**
New research shows colorectal cancer patients who have depression when they are diagnosed are significantly less likely to make a good recovery following surgery than patients without depression. The researchers say the groundbreaking study shows the important role mental health plays in cancer recovery and the need to cater for each patient's individual needs before, during, and long after their treatment has finished.

The new research is part of the largest study of its kind, by Macmillan Cancer Support and the University of Southampton - both in the United Kingdom - that is following the lives of over 1,000 colorectal cancer patients treated at 29 UK hospitals. The study covers the period from before surgery in 2010-2012 to at least 5 years afterward.

Prof. Jane Maher, joint chief medical officer of Macmillan Cancer Support, says people can
Standard 3.3 Survivorship Care Plan

“The cancer committee develops and implements a process to disseminate a comprehensive care summary and follow-up plan to patients with cancer who are completing cancer treatment. The process is monitored, evaluated, and presented at least annually to the cancer committee and documented in the minutes.”
What is included in Survivorship Care Plans

- Type of cancer, stage, and date of diagnosis
- Types and dates of cancer treatments received
- Schedule of follow-up medical visits, tests, cancer screening/surveillance
- Potential long-term and late effects
- Health behavior recommendations
- Smoking cessation, physical activity, nutrition
- Community resources
Issues Survivors Face

A New “Normal” - Adjusting to physical and emotional changes after cancer treatment, including fear of recurrence.

Follow-up medical care, wellness plan, guidelines for a healthy lifestyle.

Physical changes and issues due to the cancer or its treatment.

Family problems and issues often occur after treatment.

Employment and insurance issues.
Projected Increase in US Cancer Survivors by 2020

Number of cases

Year


65+

<65

42% ↑
Cancer Survivors are at risk for Chronic & Late Effects of Cancer

- Recurrence / new cancers
- Chronic Effects
  - Fatigue
  - Lymphedema
  - Sexual Impairment
  - Impairment
  - Functional limitations
  - Disability
  - Fatigue
  - Endocrine dysregulation
  - Recurrence/new cancers
  - Diabetes
  - Obesity
  - Osteoporosis
  - CVD
  - Obesity
  - Financial burden
  - Depression
  - Anxiety
  - Relationship changes
  - Poor body image
  - Job & Insurance problems
  - Poor body image
  - Depression
  - Anxiety
  - Relationship changes
  - Poor body image
  - Job & Insurance problems
  - Pain
  - Lymphedema
  - Poor Quality of Life
  - Incontinence
  - Functional limitations
  - Disability
  - Fatigue
  - Endocrine dysregulation
  - Recurrence/new cancers
  - Diabetes
  - Obesity
  - Osteoporosis
  - CVD
  - Obesity
  - Financial burden
  - Depression
  - Anxiety
  - Relationship changes
  - Poor body image
  - Job & Insurance problems
  - Pain
  - Lymphedema
  - Poor Quality of Life
  - Incontinence
  - Changes: purpose, priorities

© American College of Surgeons 2016—Content cannot be reproduced or repurposed without written permission of the American College of Surgeons.
Five General Guidelines for All Cancer Survivors

1. **Wellness** matters and patients are motivated to try.
2. Depression and anxiety are common. Anxiety often persists for years.
3. Cancer **fatigue** is unlike usual fatigue and can be very troubling and persistent.
4. Cancer is a **family event** and caregivers commonly experience fatigue and psychosocial distress.
5. Cancer is an **expensive** disease (and financial impact is common).
Five General Guidelines for All Cancer Survivors

1. **Wellness** matters (and patients are motivated to try.)

2. **Depression** and anxiety are common (and anxiety often persists for years.)

3. Cancer **fatigue** is unlike usual fatigue (and can be very troubling and persistent.)

4. Cancer is a **family** event (and caregivers commonly experience fatigue and psychosocial distress.)

5. Cancer is an **expensive** disease (and financial impact is common.)
What I prefer to see (as a surveyor) - BEST PRACTICES

• The whole patient is being treated.
• ALL the patients needs are being ADDRESSED
• Most of the programs I have surveyed are using ASCO survivorship materials.
• Referrals are being made.
• Exercise is being emphasized.
• The best programs have a survivorship “Evangelist” = Champion
• Liberal use of patient advocates.
• Comprehensive rehab programs are being instituted during or towards the end of active therapy(ies).
“Whole person” survivorship care creating Healthy Survivors

**Surveillance** for Recurrence, 2\textsuperscript{nd} cancers, late effects

**Intervention** for treatment consequences medical/psychosocial/economic

**Prevention** of recurrence/new CAs, late effects, new comorbidities, disability

**Coordination** between PCP and specialists to ensure all needs are met
Unmet Needs of Patients

The Cost of Surviving Cancer

Figure 20. Monetary Value of Caregiver Time in the Two Years Following Diagnosis by Cancer Type

Results – Adjusted Hazard Ratios

Hazard ratio = \frac{\text{Risk of mortality in bankruptcy group}}{\text{Risk of mortality in no bankruptcy group}}

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>n</th>
<th>HR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>17,021</td>
<td>1.79</td>
</tr>
<tr>
<td>Breast</td>
<td>3,788</td>
<td>1.48</td>
</tr>
<tr>
<td>Colorectal</td>
<td>1,430</td>
<td>2.47</td>
</tr>
<tr>
<td>Lung</td>
<td>958</td>
<td>1.55</td>
</tr>
<tr>
<td>Prostate</td>
<td>2,365</td>
<td>2.07</td>
</tr>
</tbody>
</table>

Overall, mortality risk among cancer patients who filed for bankruptcy was 79% higher [95% CI (84%, 96%) higher]

NHL: Non-Hodgkin lymphoma. Other: melanoma of the skin and cancers of the bladder and uterus. Bars represent cost estimates and lines represent 95% confidence intervals.
U.S. Health Care in Crisis

In 2014, the U.S. spent $2.9 TRILLION on health care, 18% of our GDP.

Yet, the prevailing evidence shows that patients often do not receive high-quality care.
Beyond Healthcare Reform

Medicare, Medicaid, and Social Security account for all of the projected increase in Federal spending over the next 40 years.

For the past 30 years, costs per person throughout the health care system have been growing approximately two percentage points faster per year than per-capita GDP.

Most projections assume this pattern will continue through 2050. Over time, the fiscal consequences of this rate of growth in health costs are massive.
Spending in Context

2014

- U.S. food*: $1.1 trillion
- China: personal consumption: $1.4 trillion
- U.S. health care: $2.53 trillion

Gross Domestic Product: 17.30%

* Excludes alcoholic beverages ($150 billion) and tobacco products ($92 billion)

Source: Bureau of Economic Analysis; National Bureau of Statistics of China, MGI analysis
American Healthcare Costs

16.2% of GDP in 2006
17.3% of GDP in 2009
19.3% of GDP by 2019 (projected)
25% of GDP by 2025 (projected)
Cancer Care in Crisis

It is estimated that in the decade from 2010 to 2020 that between $125 BILLION and $173 BILLION will have been spent on cancer care!
HHS introduced a proposed Medicare Part B “Demonstration Project.”

ASCO voiced its strong opposition to the project, in comments which were submitted for the June 28 U.S. Senate Finance Committee hearing.

ASCO underscored the need to …”advance a fairer and more responsible payment system for oncology than what is offered in the ill-advised proposal from CMS”—calling on CMS to withdraw the proposal or urging Congress to intervene.
The Value Proposition

The definition of “value” that is generally accepted: value is a measure of outcomes achieved per monetary expenditure.

The IOM has identified six elements of quality health care delivery: safety, effectiveness, patient centeredness, timeliness, efficiency, and equity.

ASCO has chosen to define value in cancer care by emphasizing 3 critical elements: clinical benefit (efficacy), toxicity (safety), and cost (efficiency). “THESE 3 ELEMENTS ARE READILY MEASURED, ASCERTAINABLE, AND CENTRAL TO THE MISSION OF THE CLINICAL ONCOLOGIST.” (ASCO Framework on Value Assessment)
Value = Benefit \[ \frac{\text{Cost}}{} \]
ASCOC's Latest Version of its Value Framework

- The ASCO framework was designed to provide a standardized approach to assist physicians and patients in assessing the “value” of new antineoplastic agents and regimens.
- The clinical benefit, toxicity and bonus points are added to calculate a net health benefit (NHB) score.
- “The value of a drug should not be based solely on how long it extends survival, but on the quality of that survival as well.”

Lowell Schnipper, MD
Chair, ASCO VCCTF
True Healthcare Reform
(An Efficient, Value Driven Health System)

Rational use of healthcare is necessary for the future of the U.S. economy (an issue of U.S. security).

It is possible to decrease costs and improve healthcare by using science to guide our policies and not become victims of our success.
Summary

• New standards address many important cancer related issues other than diagnosis and treatment.
• Modern oncology care requires that issues throughout the continuum are identified and addressed.
• The CoC standards empower cancer programs to provide high quality care throughout the entire continuum.
• CoC standards focus on providing quality cancer care.
Why do we need these standards?

“Knowing is not enough; we must apply. Willing is not enough; we must do.”

—Goethe
The last and most important question:

Why should we spend all of this time and money to evaluate the kind of care we should provide?
Thank you!

Questions?