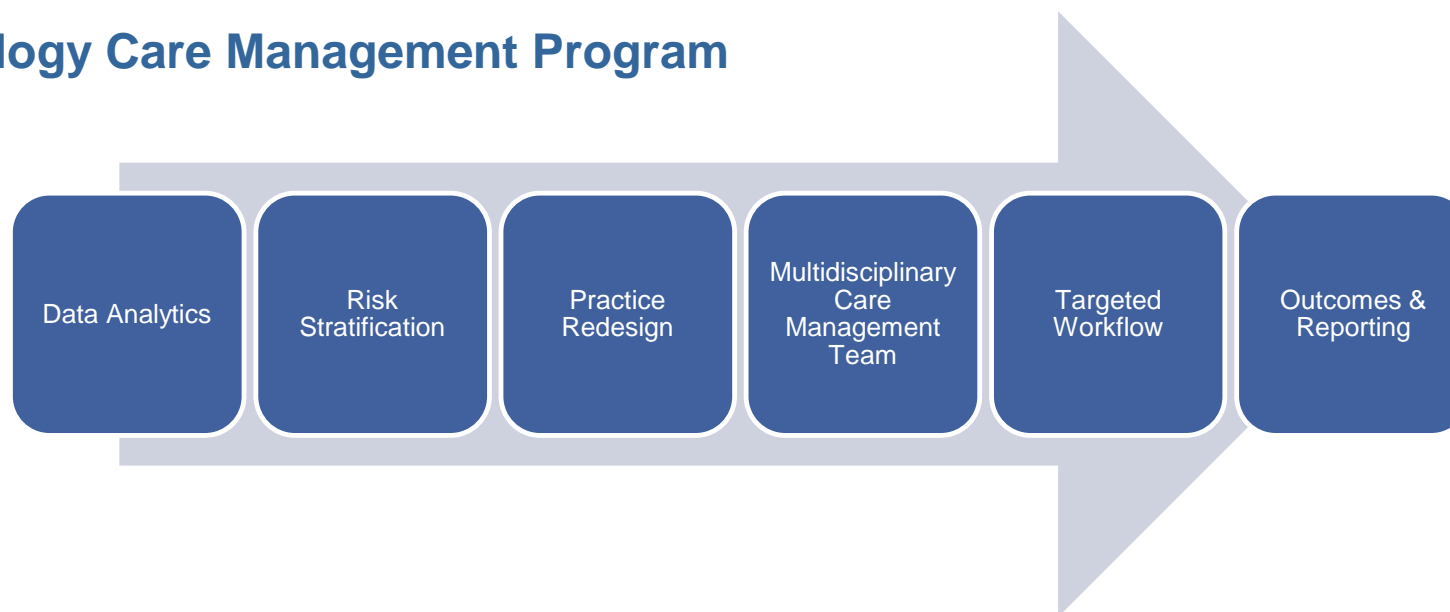# MOVING FROM TREATMENT TO PATIENT MANAGEMENT, HOW CARE MANAGEMENT CREATES A SAFETY NET FOR PATIENTS AND PRACTICES AND FACILITATES DIRECT CONTRACTING AND RISK MANAGEMENT

Oncology Care Management Program

Data Analytics → Risk Stratification → Practice Redesign → Multidisciplinary Care Management Team → Targeted Workflow → Outcomes & Reporting

Combine to ensure practice program expectations are met.

Oncology Care Management
November 16, 2016

AGENDA:

- WHO WE ARE
- ONCOLOGY CARE MANAGEMENT EXPERIENCE
- CMS PROGRAMS
- CARE MANAGEMENT CARE TEAM AND MODEL
- RISK STRATIFICATION
- GAPS IN CARE
- INTERVENTIONS TO IMPROVE QUALITY AND CARE
- PROGRAM AND GOALS
- MULTIDISCIPLINARY CARE MANAGEMENT
- EXAMPLE ANALYSIS
- SUMMARY
- QUESTIONS

Sheryl Riley, OCN, Director Clinical Programs, Caris Health

Manoj Wadhwani, President , Caris Health

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Background
- Started 2005
- Chronic & Oncology Care Management
- 25,000 covered lives
- Payer Sponsored
- Cutting Edge Proprietary Technology
- Stratification - Focused on Levels 3 and 4

Independent Practices
- Medical Billing & Collections
- Provider Medical Coding Audits & Compliance Program
- Reimbursement Audits

Health Systems & Hospitals
- Coding Audits
- Coding & Backlog Services
- Nurse Navigation & Coordination

2005

2009

2012

2014

Caris Health's Solutions
- Analytics & Patient Stratification
- Oncology & Complex Care Management
- Nurse Navigation & Coordination
- Revenue Cycle Management

Employer Groups & Case Management
- intriCare Platform
- Clinical Analytics & Reporting

Health Plans & Payers
- Oncology & Complex Care Management in the home
- Patient Centered Medical home
- HCC Coding reports

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PROGRAM OVERVIEW

- ~800 members in the study
- Enrolled for a minimum of 6 months
- Follow the same group for 18 months
- Baseline cost per member was established with client
- Control group were members who refused the program (dark green)
- Decrease in overall cost was seen from the first 6 months & increased over the 18 month period
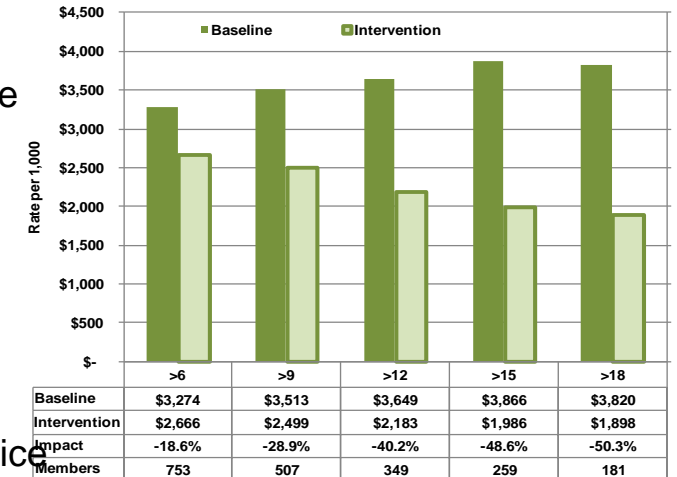- 50% savings on patients with Intervention vs Control Group

SERVICES

- Guideline Review
- Side effect management
- Home and MD office visits
- Multidisciplinary team approach
- Drug assistance programs and coordination of resources and services
- Advance life planning
- Care giver support
- Self management

OUTCOMES

- Decrease ED visits down 39%
- Decrease admits down 51%
- Hospice conversion at 8x the national average
- Treatment guidelines
- Improved treatment adherence
- Improved side effect/symptom management
- Decrease in over utilization of services
- Decrease LOS
- Improved self management
- Improved quality of life
- Appropriate referrals to palliative care & hospice

QOL Cost Impact

	>6	>9	>12	>15	>18
Baseline	$3,274	$3,513	$3,649	$3,866	$3,820
Intervention	$2,666	$2,499	$2,183	$1,986	$1,898
Impact	-18.6%	-28.9%	-40.2%	-48.6%	-50.3%
Members	753	507	349	259	181

		ENROLLMENT				
		>6mos	>9mos	>12mos	>15mos	>18mos
a	TOTAL ENROLLED MEMBERS	753	507	349	259	181
b	TOTAL ENROLLED MEMBER MONTHS	9,902	7,945	6,240	4,972	3,743
c	TOTAL BASELINE CLAIM COSTS PMPM	$ 3,274	$ 3,513	$ 3,649	$ 3,866	$ 3,820
d	TRENDED BASELINE*	$ 3,438	$ 3,689	$ 3,831	$ 4,059	$ 4,010
e	TOTAL ENROLLED CLAIM COSTS PMPM	$ 2,666	$ 2,499	$ 2,183	$ 1,986	$ 1,898
f	TOTAL PROGRAM SAVINGS [d-e]	$ 772	$ 1,190	$ 1,649	$ 2,073	$ 2,112
g	TOTAL PROGRAM COST PMPM	$ 350	$ 350	$ 350	$ 350	$ 350
h	SAVINGS NET of FEES [f-g]	$ 422	$ 840	$ 1,299	$ 1,723	$ 1,762
i	ROI [f/g]	2.2	3.4	4.7	5.9	6.0

Greater than a 20% reduction on cost and utilization with ROI Approaching 3:1 as Members gain tenure in the program

CMS, OCM PROGRAM GOALS AND OBJECTIVES – ULTIMATELY, SHIFTING PATIENT COST RISK TO PHYSICIANS, NOT SIMPLE CARE MANAGEMENT

CMS OCM Goals

The Innovation Center's Oncology Care Model (OCM) focuses on an episode of cancer care, specifically a chemotherapy episode of care. **The goals of OCM are to utilize appropriately aligned financial incentives to improve:**

- Care coordination
- Appropriateness of care
- Access for beneficiaries undergoing chemotherapy

Financial incentives encourage participating practices to work collaboratively to comprehensively address the **complex care needs of beneficiaries receiving chemotherapy treatment, and encourage the use of services that improve health outcomes.**

CMS OCM Objectives

Episode-based
- Payment model targets chemotherapy and related care during a 6-month

Emphasizes practice transformation
- Physician practices are required to engage in practice transformation to improve the quality of care they deliver
- Care coordination and nurse navigation
- Care plan creation and ongoing reassessment (13 elements of the Institute of Medicine Care Plan
- Provide 24/7 patient access to an appropriate clinician who has real-time access to patient's medical records

Multi-payer model
- Includes Medicare fee-for-service and other payers working in tandem to leverage the opportunity to transform care for oncology patients across the population

Performance-based payment
- Incentive to lower the total cost of care and improve quality of care for beneficiaries over the 6-month episode period

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*CMS, OCM, introduction slide presentation February 2015
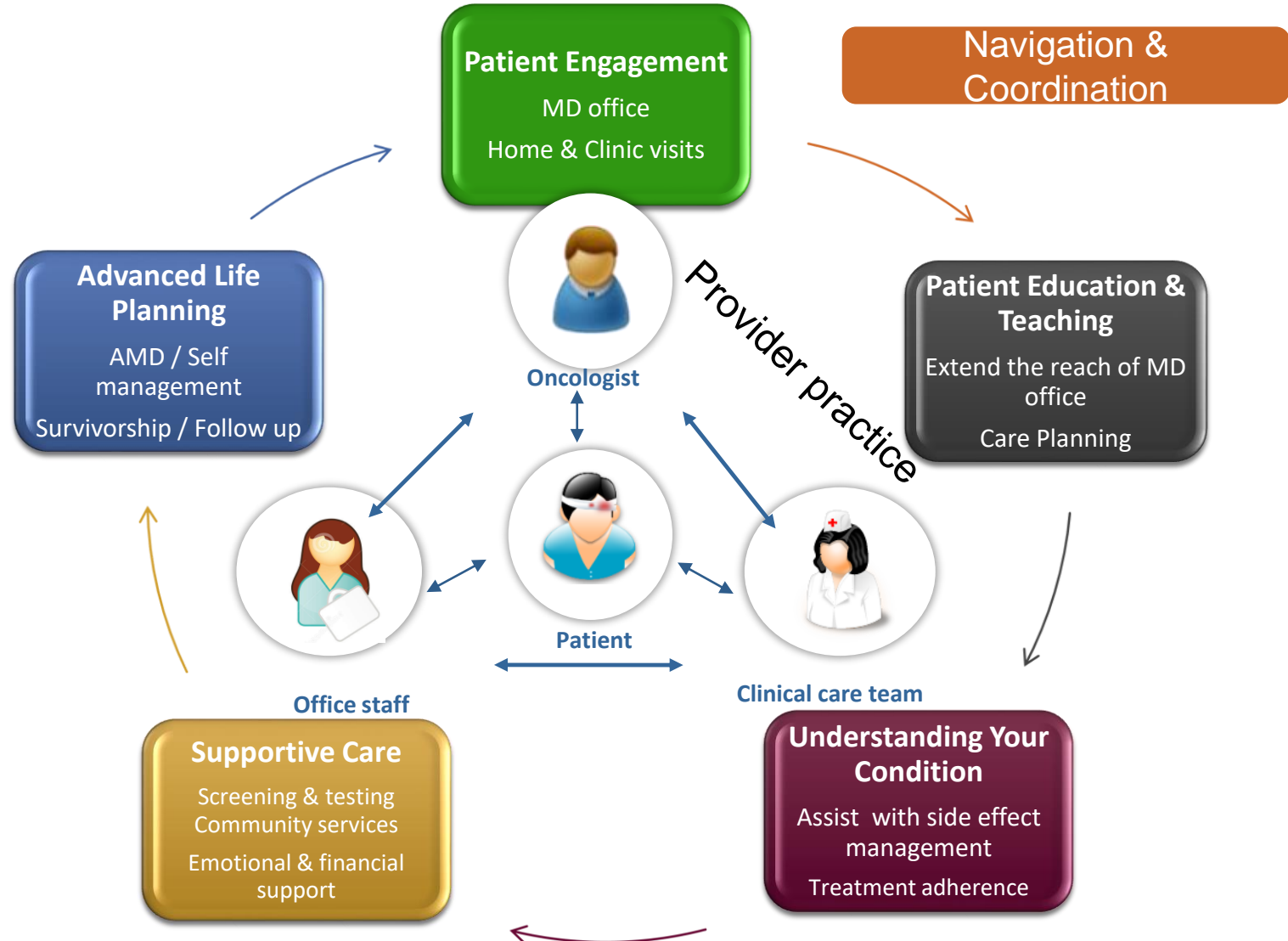
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

- MIPS is a new program for certain Medicare-enrolled practitioners starting in January 2017
- MIPS is focus on quality, resource use, and use of certified EHR technology (CEHRT) in a cohesive program that avoids redundancies
- MIPS would consolidate components of three existing programs
  - Physician Quality Reporting System (PQRS)
  - Physician Value-based Payment Modifier (VM)
  - Medicare Electronic Health Record (EHR) Incentive Program for Eligible Professionals (EPs)
- Key drivers for MIPS are:
  - Quality metrics such as care planning and medication validation (replacing PQRS)
  - Improvement activities (new)
  - Advancing Care Information (replacing meaningful use)
  - Cost (replacing the Value Based Modifier)

GAPS IN CARE RELATED TO TREATMENT VS PATIENT- CARE MANAGEMENT (IMPROVE QUALITY METRICS)

Care Phase	Gaps	Consequences	Care management
Prevention and screening	• Ineffective identification of eligible patients • Inability to reach underserved populations • Appointment wait times too long • Patients not contacted with abnormal test results	• More patients develop preventable cancer • Patients seek screening elsewhere • Cancer is detected at a later stage	• Engage patients • Coordinate screening and prevention • Set up follow up visits • Patient education in the home to follow up on tests and screening process
Diagnosis and closing the referral	• Referrals not made • Patients not understanding diagnosis • Not documenting co-morbidies	• Patients seek care elsewhere or not at all • Treatment is delayed • Co-morbidities are not addressed which can affect cancer care	• Coordinate referral • Obtain notes and test from MD visits • Documenting and coding pt co-morbidies • Risk stratification
Treatment Medication validation	• Lack of patient compliance • Missed clinical trial accruals • Fracture care experience	• Patients miss neo-adjuvant opportunities • Outcomes are inferior • IP and ED utilization are higher • Side effects that could be avoided	• Visit patient in the home • Follow up on teaching and treatment plan • Medication validation and adherence • Identify barriers to care
Pain management	• Lack of standard process for documenting pain • Lack of standard process for documenting depression	• Pain goes untreated • Patient goes to ED or hospital • Poor patient treatment outcomes	• Pain is assessed initially • Pain is assessed with each visit • Communicate pt's pain and changes with oncologist
Care plan and Survivorship	• Lack of coordinated follow-up services	• Patients seek care elsewhere	• Creation of care plan • Ongoing reassessment • Shared with patient and family
End-of-Life Care	• End-of-life issues not proactively addressed	• IP utilization is high • Palliative care is insufficient • Patients miss palliation opportunities	• Begin conversation early • Work with oncologist to have pt and family conversation • Set up local and regional services

CARE MANAGEMENT PROVIDES TOOLS – TESTED AND PROVEN FOR YEARS FOR PAYER RISK MANAGEMENT EXPECTATIONS

Components of Program

- Retrospective Data Review to Identify areas of improvement for each individual practice's transformation
  - Integrates Participating Plan data on whole spend and treatment of cancer patient (not just cancer related)
- Risk Stratification, Analysis, and Patient Identification
- Multidisciplinary Care Management Plan
  - Coordination of services and coordination of care (templates built into system identifying what specific and frequency of interaction and assessments are appropriate for each individual patient)
- Utilizing intriCare Technology & Workflow
- Registry, Reporting, & Outcomes
  - Population reporting on disease, outcomes, total vs. cancer spend and outcomes, per MD, in hands of MD

Patient Engagement
MD office
Home & Clinic visits

Navigation & Coordination

Advanced Life Planning
AMD / Self management
Survivorship / Follow up

Oncologist

Provider practice

Patient Education & Teaching
Extend the reach of MD office
Care Planning

Patient

Office staff

Clinical care team

Supportive Care
Screening & testing
Community services
Emotional & financial support

Understanding Your Condition
Assist with side effect management
Treatment adherence

PHYSICIAN AND ONCOLOGIST COORDINATION AND SUPPORT

- Extending the physician care plan management and reinforcing treatment regimens and medication adherence
- Proactive side effect management with 24/7 telephonic support
- Supporting the patient, caregiver and family with emotional support, advocacy, coordination of services (home care, DME etc.) and referral to other needed services
- Manage and coordinate between physician practices including co-morbid conditions
- Ongoing care plan adjustments and re-establishment of goals based on changes in condition and treatment
- Identification and Coordination Drug Assistance Programs and Financial Assistance with Co-pays
- Coordination of Clinical Visits, Resources & Services
- Community Outreach
  - Home visits with RN care manager and social workers
  - Visit the patient while in the hospital to assure improved transitions of care
  - Encourage self management when appropriate
  - Assess for nutritional status and exercise
- Tele-monitoring devices if necessary

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ACUITY SCORES ARE COMPLEX

FIRST SCORE
- Factor 1 = Financial **(0-30)**
- Factor 2 = Diagnosis **(0-440)**
- Factor 3 = Demographic **(0-10)**

SECOND SCORE
- **Factor 4 = Disability (0-120)**
- Bucket 4.0 = HRA & Telephone Screen
- Bucket 4.1 = SF 12
- Bucket 4.3 = Nutrition Screen
- Bucket 4.4 = Depression Screen (Age Dependent)
  - GDS (Geriatric Depression Scale) Short Version
  - CES-D (Center for Epidemiologic Studies of Depression Scale)
- Bucket 4.5 = Lawson

Cancer treatment
- Moderately toxic
- Highly toxic
- Bone marrow transplant
- Clinical trial
- Radiation therapy
- Prior history of cancer and treatment
- Cancer surgical interventions

THIRD SCORE
- Home visit, barriers
- Environmental and home assessment
- Care expectations

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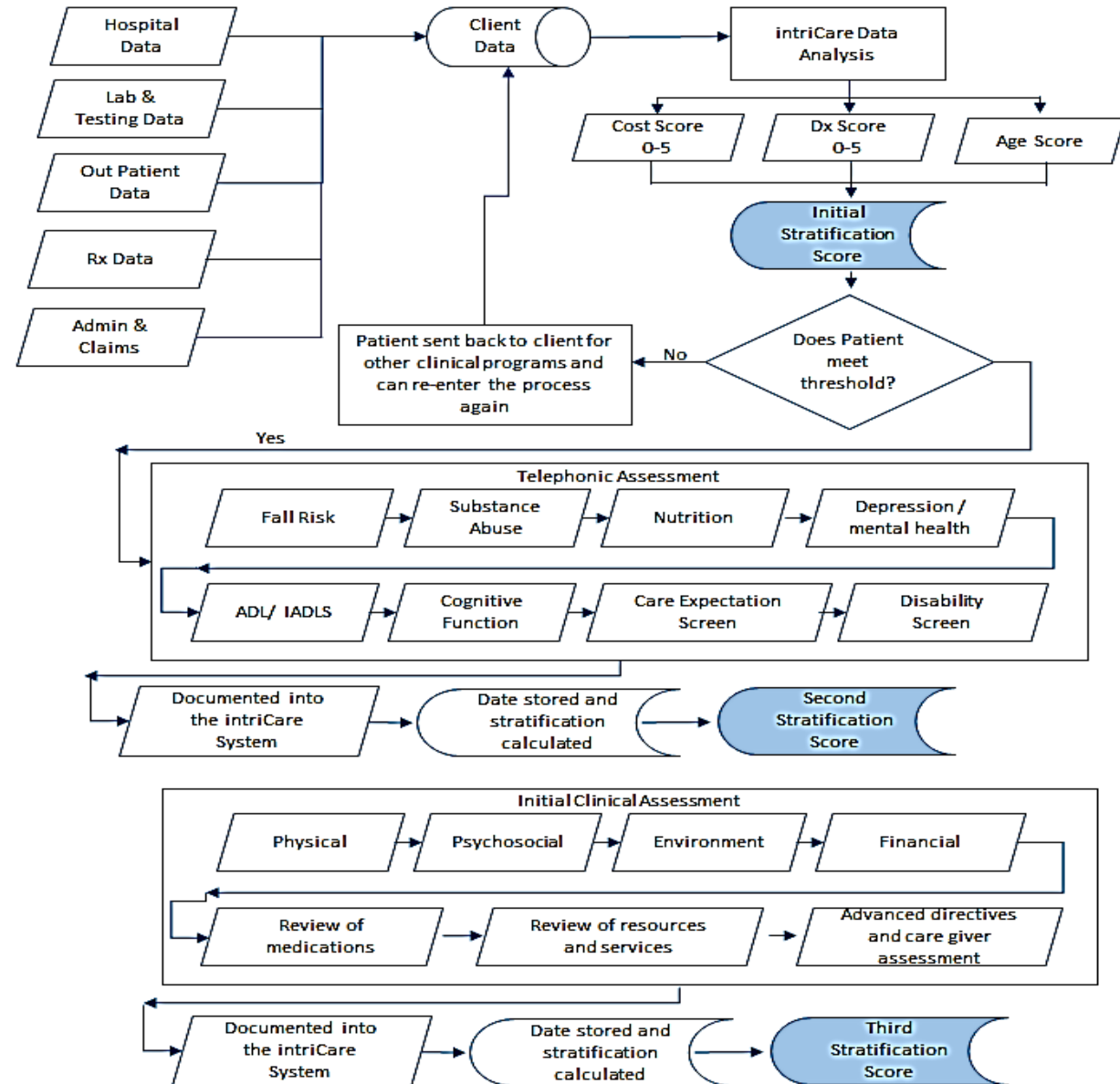
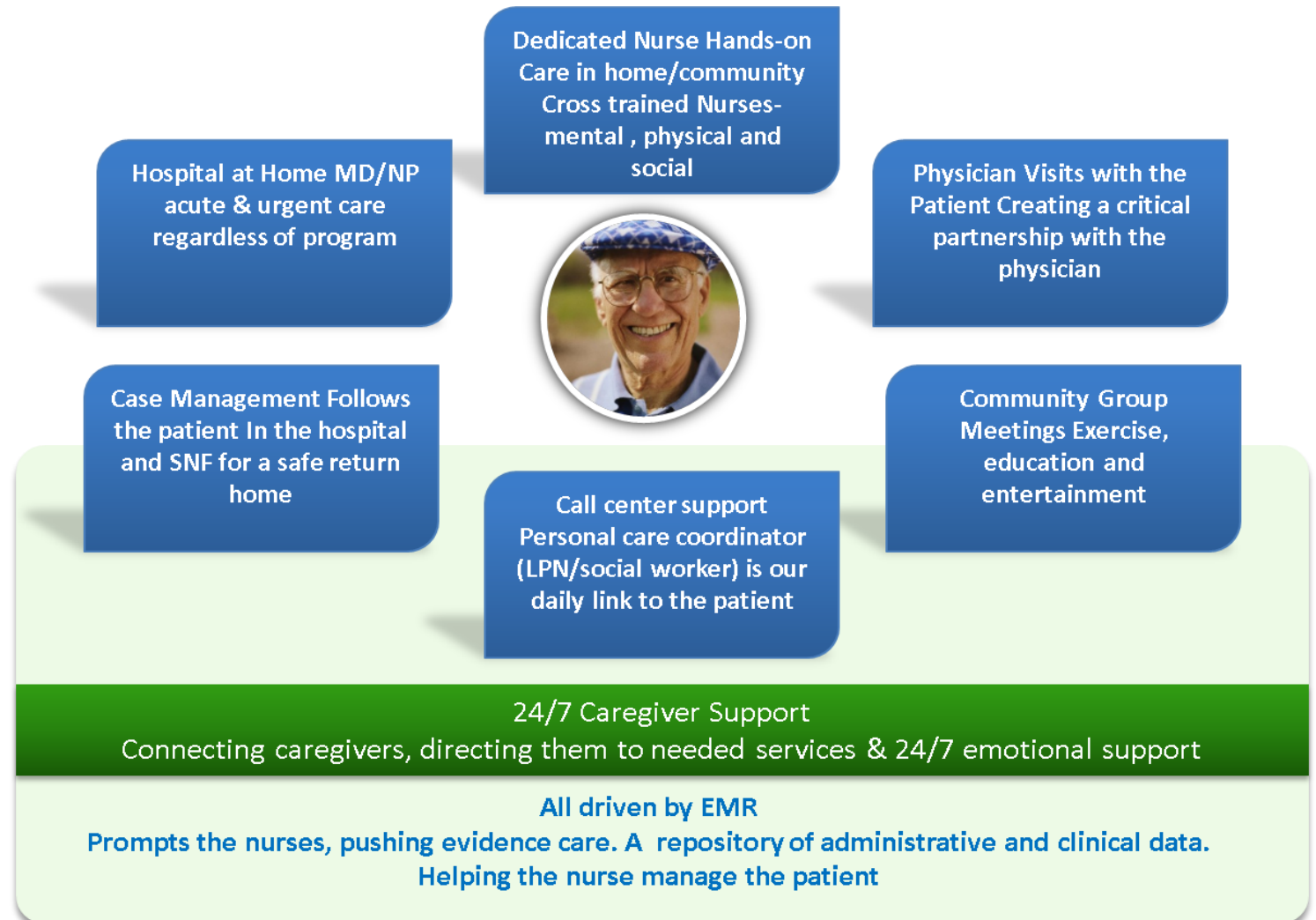# ONCOLOGY CARE MANAGEMENT LEVELS AND GOALS

Care Management Intervention	Level 1 – Minimally Toxic Treatment	Level 2 – Moderately Toxic Treatment	Level 3 – Highly Toxic Treatment	Level 4 – Recurrent Metastatic and/or Advanced Disease
National Guideline	Review regimen. Evaluate appropriateness with nationally accepted guidelines (NCCN, ASCO).			
Guideline vs. Clinical Trial		Review treatment regimen against guidelines. Evaluate appropriateness. Encourage use of clinical trials where appropriate.		
Regimen Compliance, medication validation and Clinical Management	Educate and support patient through treatment Encourage self management. Assist with services when appropriate.	Educate patient and family on treatment regime and identify any barriers for non-compliance. Assist patient in setting up appointments and obtaining home, health and community resources and services needed. Set care expectations with patient and family. Drug and financial assistance where appropriate.		
Side Effect Management	Educate patient on side effects of treatment regimen. Self management. Encourage to call if problem.	Educate patient and family on proactive management of medication and treatment side effects. Decrease risk of infections. Encourage good nutrition and hydration. Call if side effects become worse or new side effects occur. Set up activity level with patient and family, encourage activity with rest periods. Utilize supportive drugs where appropriate.		
Prevent and Minimize ER visits	Review claims data for patient history of admissions and ER visits. Educate patient to call nurse or MD before going to hospital unless emergency (temp 101 or greater) etc. Educate patient and family to monitor side effects, keep regular scheduled appointment for treatment and lab word. Monitor weight, hydration, temperature, follow side effect protocol.			
Pain Management	Self management of pain control with education and monitoring.	Assess for pain upon each patient touch, utilize pain scale, keep patient at 4 or below. Obtain standing orders to assist with pain control, instruct patient to call for break through pain.		
AMD and End of Life Management	Encourage patient and family to discuss living will and advance directives.	Educate patient and family on the importance of advanced medical directives and living wills.	Educate and encourage patients and families to review and maintain AMDs and a living will. Educate patient and family on supportive care.	Educate and encourage patients and families to review and maintain AMDs and a living will. Discuss palliative care and when appropriate Hospice.

CARE MANAGEMENT CREATES A PATIENT SAFETY NET

Care Touch Points:

- Assist in patient and family engagement
- Collaboration with the office staff
- Patient stratification
- Extend the reach of the practice into the patients home and community
- Identify and Coordinate community resources & services
- Assist with patient symptom management
- Assist with setting care expectations
- Smoother care transitions
- Drug and financial assistance
- Encourage self management
- Assistance with clinical trials

Multidisciplinary Care Team

Dedicated Nurse Hands-on Care in home/community Cross trained Nurses- mental , physical and social

Hospital at Home MD/NP acute & urgent care regardless of program

Physician Visits with the Patient Creating a critical partnership with the physician

Case Management Follows the patient In the hospital and SNF for a safe return home

Community Group Meetings Exercise, education and entertainment

Call center support Personal care coordinator (LPN/social worker) is our daily link to the patient

24/7 Caregiver Support
Connecting caregivers, directing them to needed services & 24/7 emotional support

All driven by EMR
Prompts the nurses, pushing evidence care. A repository of administrative and clinical data. Helping the nurse manage the patient

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CARE MANAGEMENT SOFTWARE CREATES INTEGRATION & WORKFLOW

- Centralized platform encompasses entire clinical & management team
- Multi-disciplinary care plan
- Integrating with physicians and health care teams EMR's
- System deploys in all healthcare settings
- Streamline care coordination & community services management
- Improved patient education & self management
- Comprehensive transitions of care
- Increased staff productivity and efficiency
- Enhanced real time communication
- Centralized and timely information
- Robust reporting

ANALYSIS

| Claims | Stratification | Patient Identification |

PATIENT ENGAGEMENT, TREATMENT PLAN & CARE MANAGEMENT

| Patient Engagement | Review of Physician Treatment Plan | Care Plan Management | Care Coordination |

ONGOING MANAGEMENT & REASSESSMENT

| Patient Tracking Alert | Reassessment | Ongoing Care Management & Care Coordination | Treatment plan review |

OUTCOMES

| Health Tracking & Dashboard | Patient Stratification | Clinical & Financial Reporting |

Legend:

→ Interface with plan sponsor or physician

→ Interface with member/patient

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CARE MANAGEMENT - BRINGS BOTH TOUCH AND TECHNOLOGY TO THE PRACTICE

Patient Care Navigation/Coordination

- Caris Health team works within the practice
- Multi-disciplinary care team collects patient data not usually collected by the practice which can assist the oncologist
- Clinical, community based targeted intervention
- Home and group visits
- Ongoing risk stratification
- Improve transitions of care
- Hospital Avoidance
- Assist with referrals for palliative, supportive and hospice care
- Assistance with co-morbidity management
- Assist with communication with PCP and other specialists

Payer Oncology Management, Analytics & Reporting

- Analyze Medicare and Private Payer Claims Data
- Stratification of Patients into severity and acuity levels
- Meets all CMS reporting requirements for CMMI programs such as OCM and MIPS
- Identify population, group and MD Level – care costs, level of acuity and concordance with evidence
- Identify both successes and outliers for care management and navigation
- Utilizing clinical data not normally collected to improve care, process and outcomes
- Improve reporting capabilities, by physician and practice

ACTIVITIES OF THE CARE TEAM MEMBERS – HOW THEY SUPPORT PRACTICE INFORMATION AND WORK FLOW

Nurse

- Clinical Assessment
- Collaboration with Oncologist & team
- Treatment Plan Review
- Standardized Testing
  - Functional / Cognitive
  - Nutrition / Exercise
  - Behavioral /Falls Risk
- Care expectations & Patient Education
- Home Visits / Joint Visits with MD
- Advocacy / Emotional Support
- Assistance with Clinical Trials
- Follow up care/survivorship
- Ongoing reassessment & Coordination of needs

Social Worker

- Psychosocial Assessment
- Environmental Assessment
- Financial Assistance
- Community Resources
- Address emotions, fears & concerns
- Home Visits
- Community Services:
  - Transportation
  - Babysitting
  - Drug assistance
  - Referrals for social services
  - Referrals for HHS
  - Referral for behavioral health
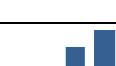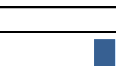
Care Coordinator
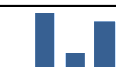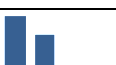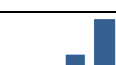
- Health Risk Assessment
- Telephone Screening
- Coordinate & monitor ancillary services
- Assistance with scheduling:
  - PCP
  - Specialist
 - Testing
  - Screening
- Follow up calls

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DATA ANALYSIS

STRATIFICATION / CARE LEVEL SUMMARY

|	Total 1532 members			
	Level-1	Level-2	Level-3	Level-4
Maximum Cost	$ 49,567.21	$ 117,757.87	$ 171,752.50	$ 1,060,724.44
Median Cost	$ 2,534.12	$ 13,632.72	$ 44,720.86	$ 100,840.71
Total Cost	$ 3,228,652.72	$ 9,944,720.28	$ 5,181,436.12	$ 9,007,867.73
Member Count	798	565	100	69
Avg Cost	$ 4,045.93	$ 17,601.27	$ 51,814.36	$ 130,548.81
Minimum Acuity	30	76	151	201
Maximum Acuity	75	150	200	484
Male/Female Count	442/356	210/355	42/58	29/40

OBSERVATIONS:
- The average cost per member is going up by level of care (Level 1 being the healthiest) and the numbers of members per level is going down.
- It is important to note the large jump in cost from Level 2 to 3 and then 3 to 4. By introducing telephonic care management with tele-monitoring in Level 2 it would help to keep the patient in the lower cost levels for a longer period of time and to control cost.
- By adding community embedded care management to Levels 3 and 4 you can substantially control cost and improve patient care.

COST BY LEVEL OF CARE
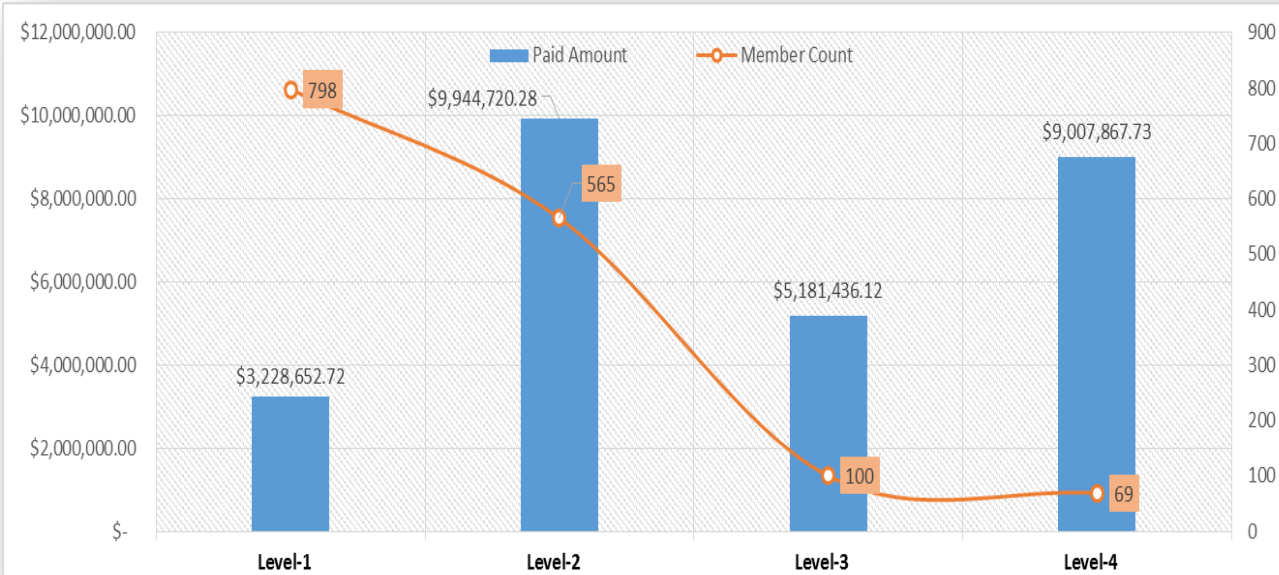

Cost and Member Count by Care Levels:
- Level 4 is the sickest population (i.e. having a higher acuity score as compared to Level 1).
- The cost is inversely proportionate to the member population in that care level bucket.
- Beginning wellness programs focused on diet exercise and preventative screening and test will help keep more Level 1 and 2 healthier for a longer period of time and might reverse early signs of illness such as obesity, diabetes, high cholesterol and hypertension
- Applying telephonic and tele-monitoring care management to Level 2 will help to keep them at Level 2 for a longer period of time and help to slow symptoms of certain conditions such as obesity, diabetes, high cholesterol and hypertension
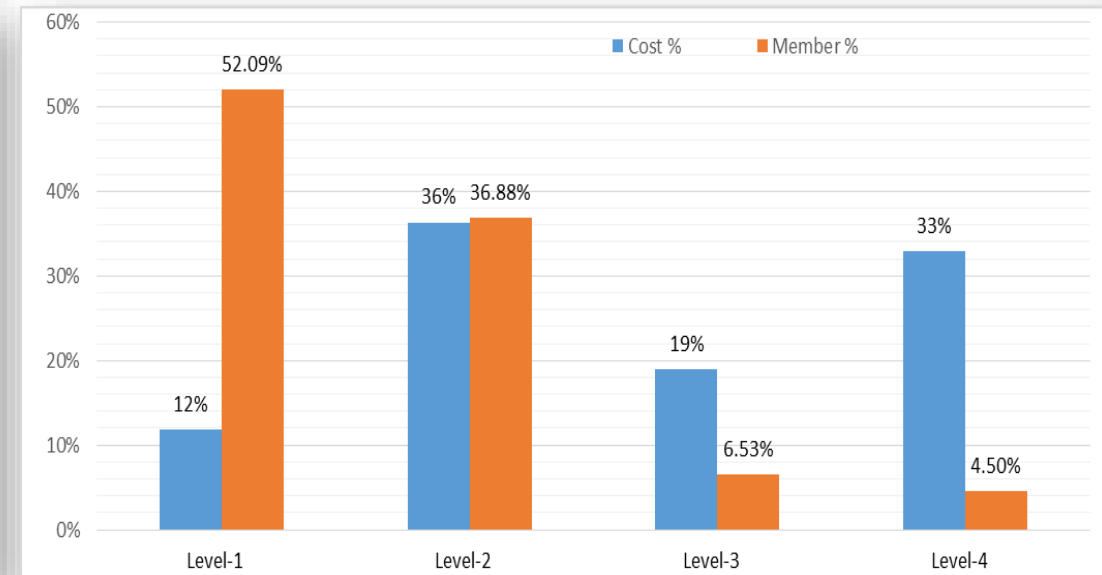
Cost and Member Count by Care Levels:
- Level 4: 33% of the total cost is spent on 4.5% of the population.
- Level 3 and 4 combined: 51 % of total cost is spent on just 11.03 % of the entire population.
- Applying care management to the 11.03% will significantly reduce cost and improve quality of care
- Applying community embedded care management to Level 3 and 4 improves the quality of care and decreases cost by monitoring patient care, educating patient on treatment option and side effects and coordinating resources and services for the patient which helps to keep them in their home and out of ED and hospital

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COST BY PLACE OF SERVICE AND TRUE ED COST
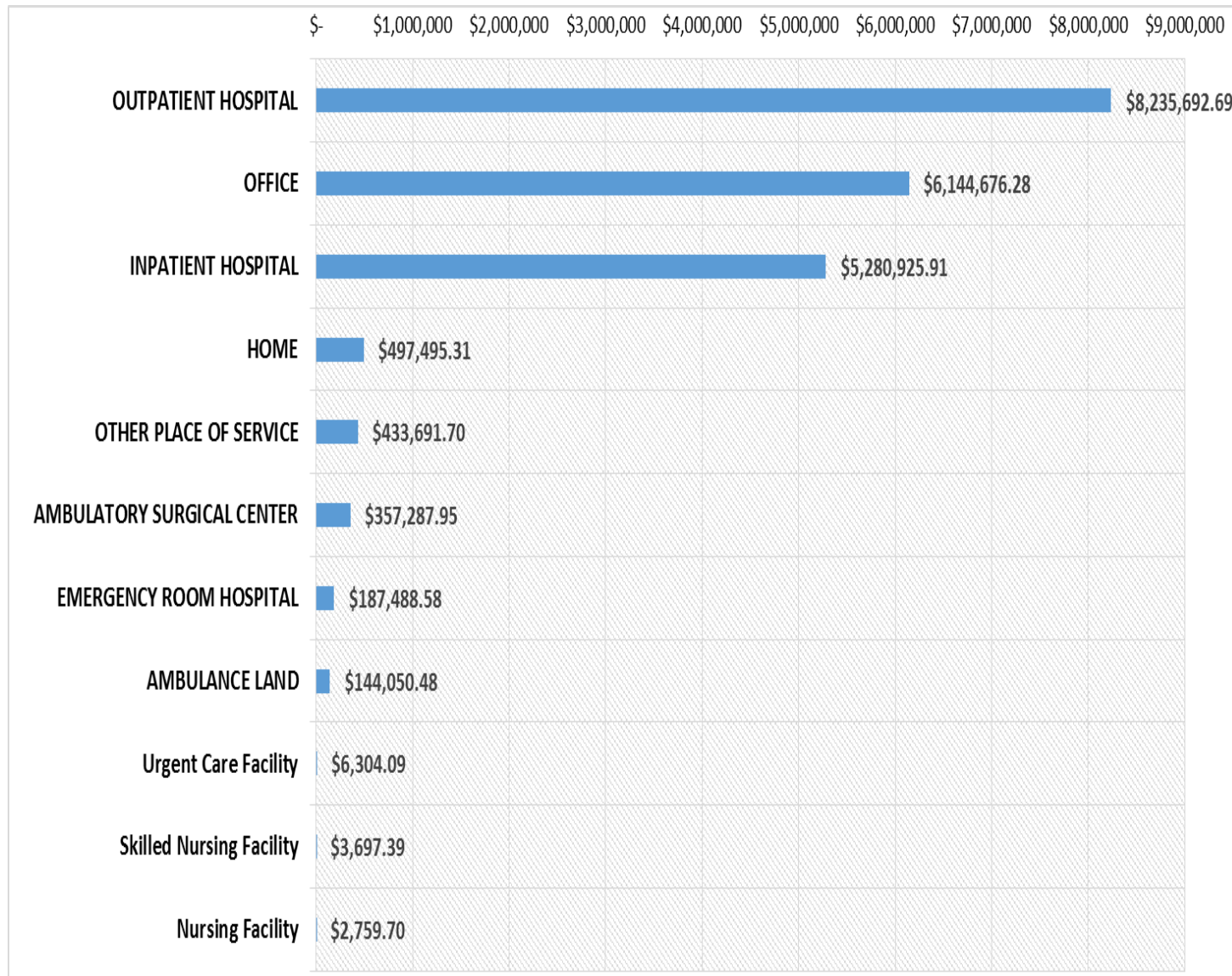
Place of Service	Paid Amount	Amount %
OUTPATIENT HOSPITAL	$ 8,235,692.69	38.7%
OFFICE	$ 6,144,676.28	28.9%
INPATIENT HOSPITAL	$ 5,280,925.91	24.8%
HOME	$ 497,495.31	2.3%
OTHER PLACE OF SERVICE	$ 433,691.70	2.0%
AMBULATORY SURGICAL CENTER	$ 357,287.95	1.7%
EMERGENCY ROOM HOSPITAL *	$ 187,488.58	0.9%
AMBULANCE LAND	$ 144,050.48	0.7%
Urgent Care Facility	$ 6,304.09	0.0%
Skilled Nursing Facility	$ 3,697.39	0.0%
Nursing Facility	$ 2,759.70	0.0%

The top 3 places of service buckets consumes 90% of the cost.

* Below is the break out of true ED costs:

Emergency Room hospital = $ 187,488.58
Transportation to ED = $ 144,050.48
Emergency cost built into IP = $ 72,367.61
Emergency cost built into OP = $ 373,578.47
**Total = $ 777,485.14
4.25%**

Care management services can assist in decreasing ED visits.

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# COST BY LEVEL OF CARE AND PLACE OF SERVICE

Place of Service Cost in each Care Level
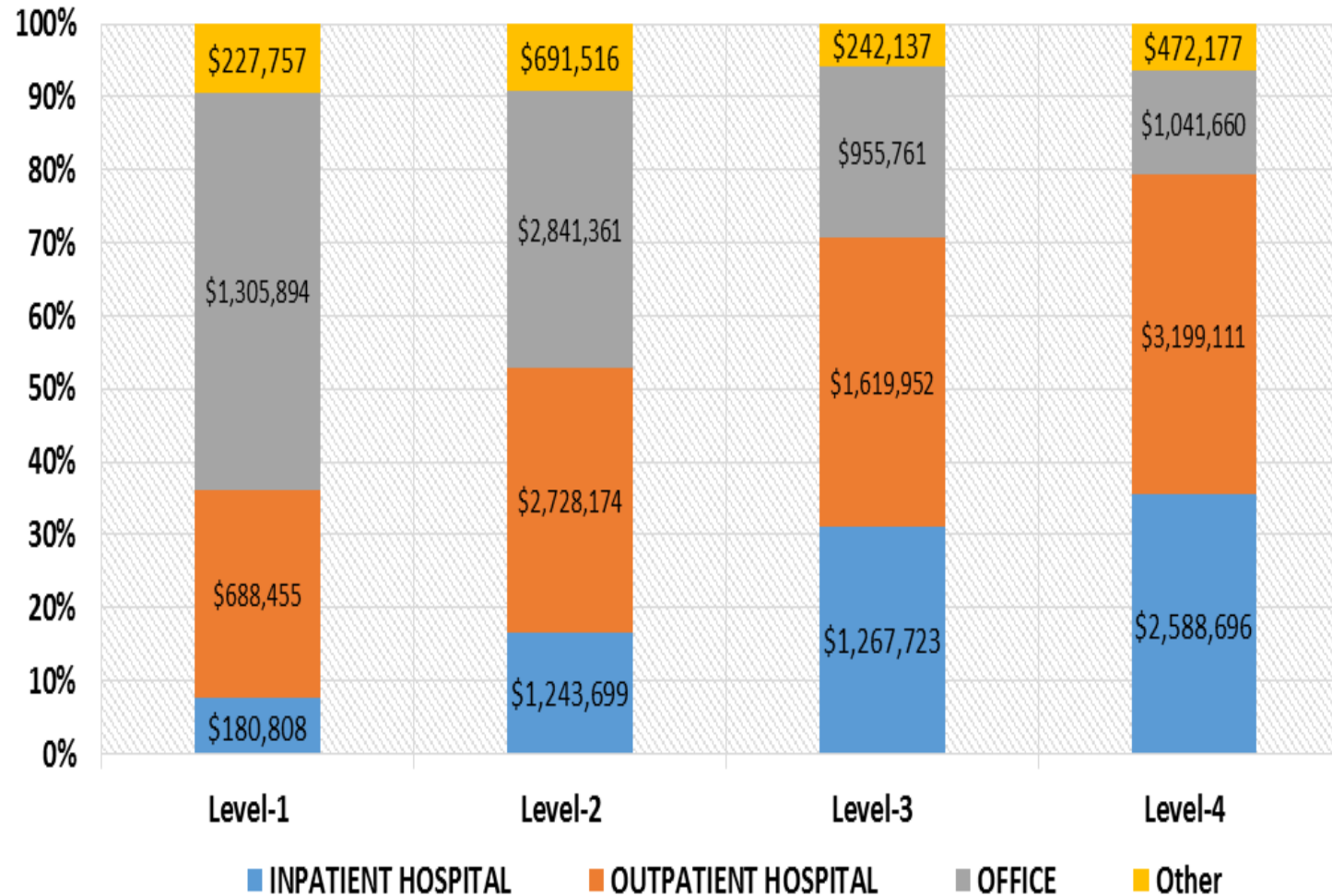
- Inpatient and out patient cost increased as acuity increased.

- Largest spike Level 2 to 3 & 3 to 4.

- Office visits decreased as the patient became sicker.

- Caris Health's Care Management can assist with decreasing risk of hospitalizations, ED's, and the appropriate use of palliative care and hospice.

ANALYSIS OF TOP 10 PROVIDER GROUPS

Member Count	324	280	294	530	506	168	590	307	10	264
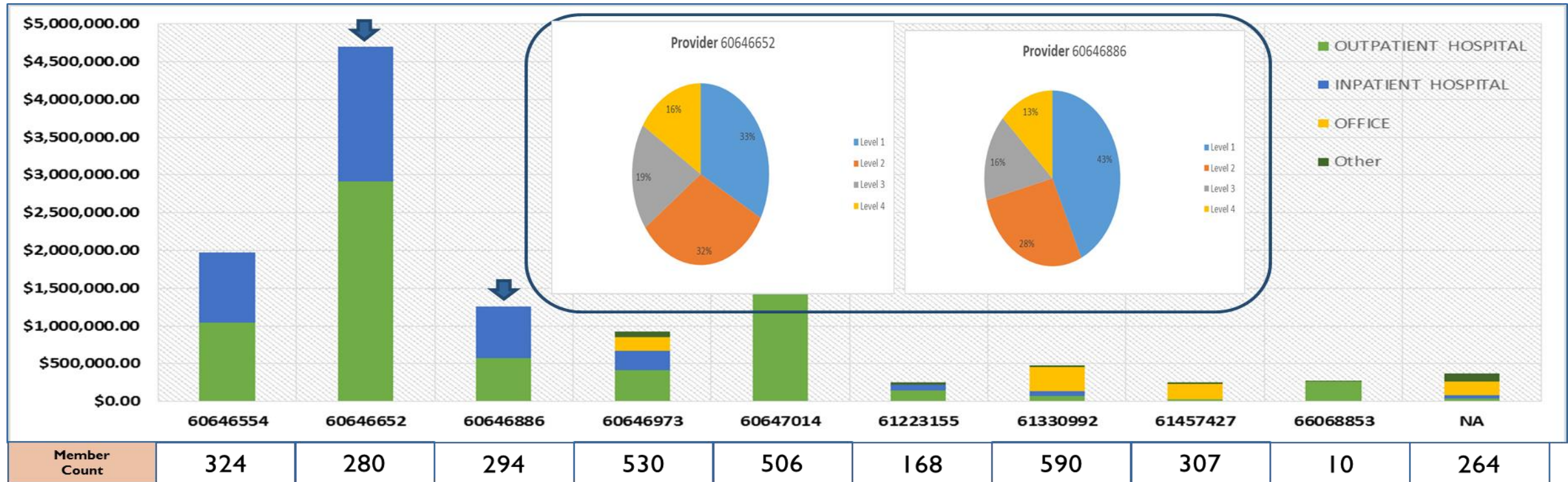
- Provider xxx652 charges more for their services than provider xxxx886.
- If possible direct more members to provider xxxx886 as long as the quality is the same
- Negotiate better comparable rates with provider 652
- Provider 652 has more Level 3/4 patients than Provider 886 resulting in 652's services and patient cost being 3x higher

- Total $21,294881 medical cost is paid among 1661 providers
- The 55% of medical cost is with the top 10 providers.
- Provider xxx652 and Provider xxx886 have similar member count but cost difference is huge, one costs 38% of total cost and other costs 10% of total cost
- Provider 652 costs are 38% of total cost
- Provider 886 costs are 10% of total cost
- Provider 652 has more patients in Level 3 and 4
- Provider 866 has more patients in Level 1 and 2

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PROVEN VALUE OF ONCOLOGY CARE MANAGEMENT

Patient

- Expand survivorship programs for patients & families with self management driven care plans
- Self management & shared decision making
- Continuity of care
- Better informed, improved access to care and improved adherence to treatment
- Reduce unnecessary visits & tests
- Empowerment & advocacy

Provider

- Expanding the view for the physician to outside the office into the home & community
- Increased patient information regarding acuity and co-morbid conditions
- Improve communication
- Improve patient compliance with prevention, screening & testing
- Improved overall patient experience, adherence & quality of life

Payer

- Reduce cost
- Reduce hospitalization and re-admissions
- Reduce utilization of repetitive services
- Reporting & outcomes

THANK YOU

FOR MORE INFORMATION EMAIL WECARE@CARISHEALTH.COM I WWW.CARISHEALTH.COM

203 929 0790 OFFICE
203 929 6978 FAX

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QUESTIONS?

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# REPORTING OF CMS / OCM (PHYSICIAN FOLLOW UP & SURVEYS)

CMS has requested very specific clinical, operational and patient related metrics that need to be collected, monitored and reported. Below are just a couple of examples:

- **Report reflects patient follow up post discharge**
- **Goal is to have the patient in front of the oncologist within a 5 day window**
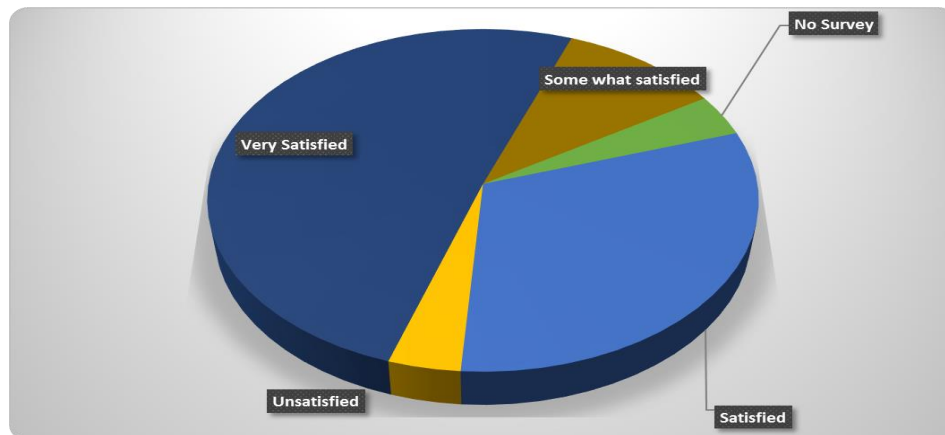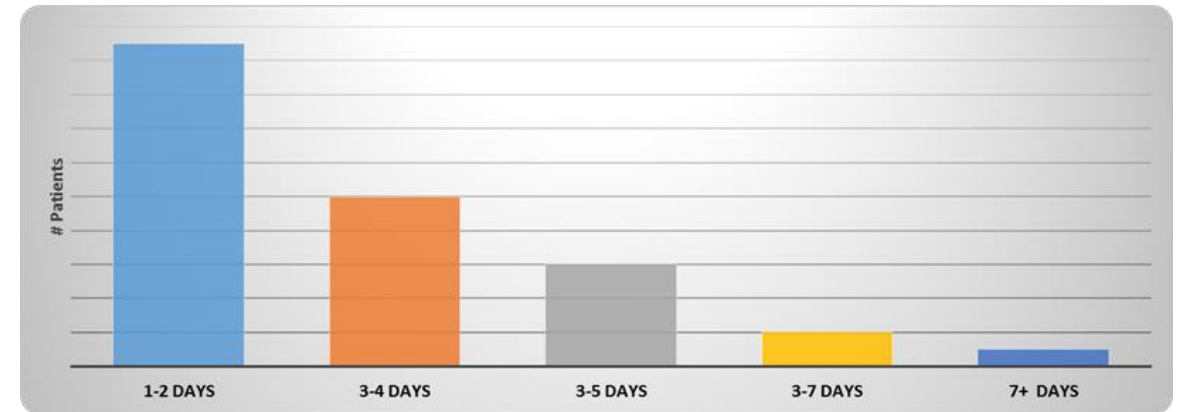
- **Member satisfaction, reflects patient experience with our clinical programs**

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REPORTING OF CMS / OCM (UTILIZATION/TREATMENT/METRICS)
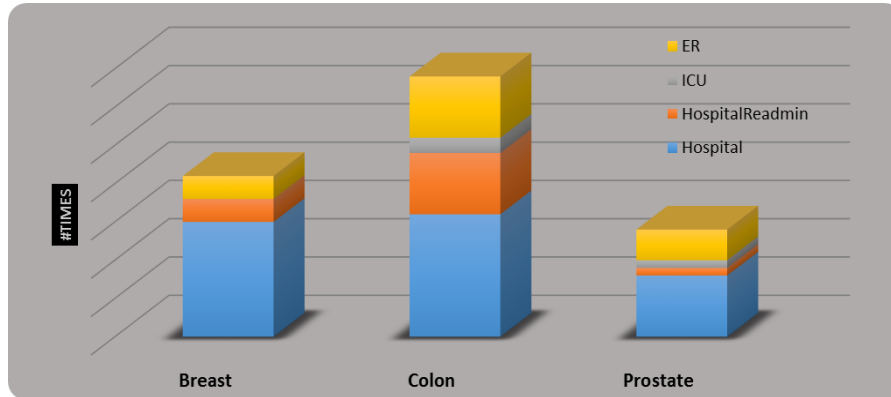
- **Reporting representing utilization by cancer type**
- **Identify utilization by provider by cancer type**
- **Assist in understanding provider utilization patterns by cancer diagnosis**

- **Reporting of treatment types by cancer diagnosis**
- **Helps to establish how oncologist are treating**
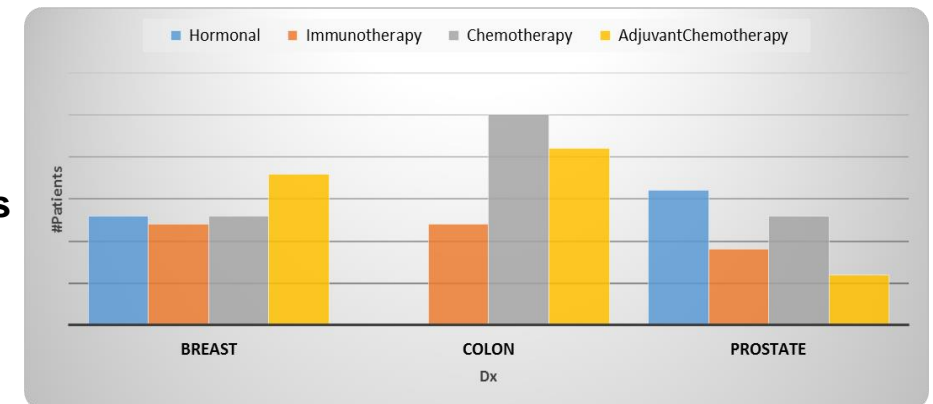
- **Report represents some of our established clinical metrics, evidenced based guidelines and operational process**
- **Track metrics, guidelines and operational process to identify areas of improvement**