

Track, Measure, and Report: The Navigator's Contribution to Value-Based Care

ONA Navigation Summit

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Alaysia Williams, MHA

Program Coordinator II, Oncology Service Line

Mount Sinai Health System



**Mount
Sinai**

Agenda

1. Navigation in Value-Based Oncology Care
2. Mount Sinai's Navigation Model
3. Tracking Metrics Using Interactive Dashboards

~2,500 full time faculty
physicians

Over 1,000 voluntary
physicians

8 hospitals spanning
Manhattan, Brooklyn, Queens,
and Long Island

*Geographic access
and coverage
across the five
boroughs, Long
Island,
Westchester and
Florida*

12 ambulatory
surgical centers



**Mount
Sinai**

Over 300
community
locations

Committed to a vision of transforming health care in New York towards value-based care and population health

More than **110** full-time faculty
physicians

155 dedicated oncology beds

8 hospital-based infusion
centers

4 Ambulatory
Radiation
Oncology Sites

125 ambulatory
exam rooms



**Mount
Sinai
Cancer**

126 infusion
chairs

10 Cancer
Network Practice
Sites



Navigation in Value-Based Oncology Care

CMMI Oncology Care Model

Oncology Care Model Design

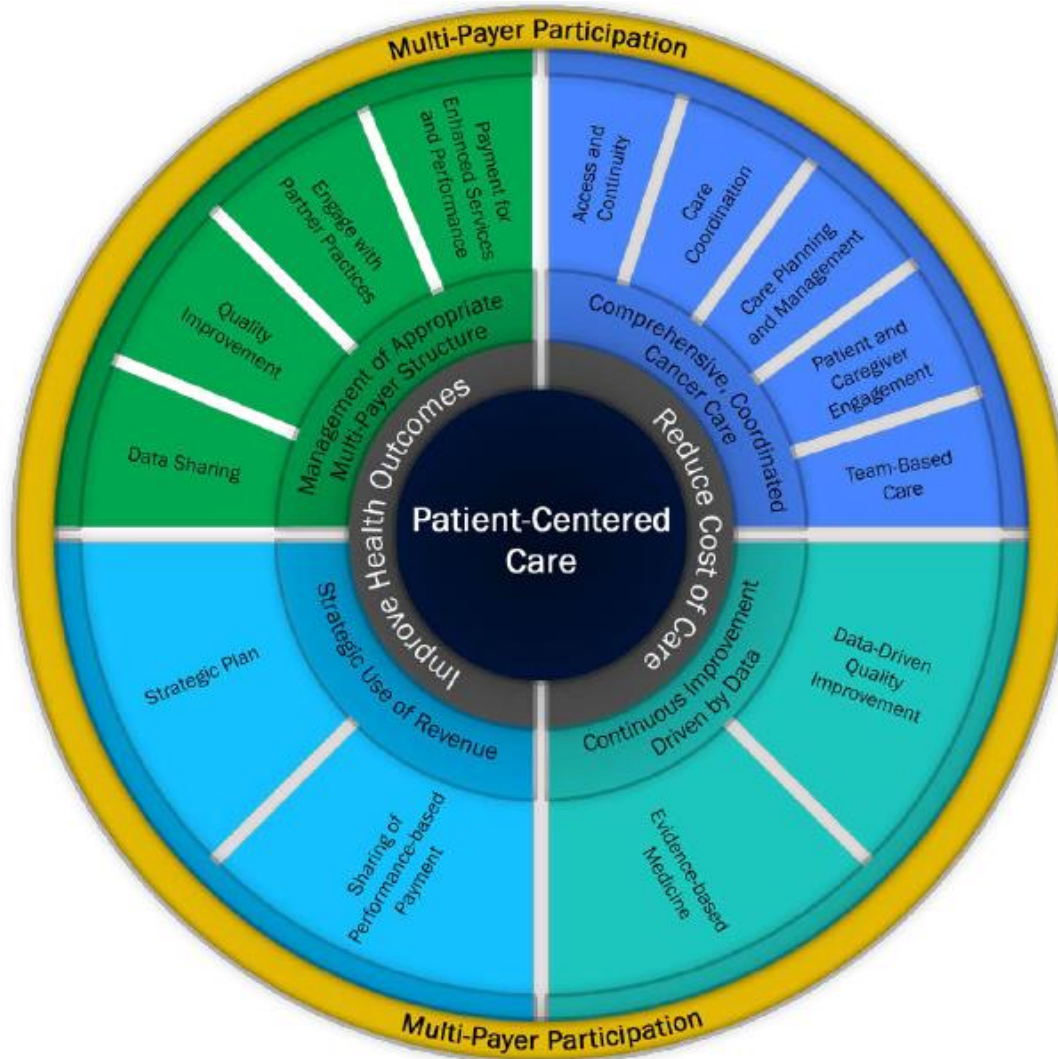
- ▶ 5-year Alternative Payment Model organized in six-month performance periods
- ▶ Started July 1, 2016; Medicare FFS patients only
- ▶ 6-month episodes of care triggered by outpatient chemotherapy or hormone therapy
- ▶ \$160 PBPM payment for practice transformation and enhanced oncology services
- ▶ Opportunity for performance-based payment (PBP) with one or two-sided risk

Performance Evaluation

- ▶ Performance is measured by:
 - Total cost of care vs. target price for episodes of care
 - OCM quality measure results
- ▶ Participants are required to report on and improve quality while achieving total cost of care below a beneficiary-specific target price

The goal of the Oncology Care Model is to incentivize high-quality, coordinated care with an episode-based payment model that emphasizes patient access and navigation.

Oncology Care Model Driver Diagram



Primary Driver: Comprehensive, Coordinated Cancer Care

Secondary Drivers

Required Practice Redesign Activities

Access & Continuity

- Provide 24/7 access to an appropriate clinician who has real-time access to patients' medical records
- Increase access to visits
- Provide access to care and information outside of visits

Care Coordination

- Provide core functions of patient navigation (PN)
- Conduct coordinated medication management (for IV and oral therapies)
- Support referral coordination and management (core function of PN)
- Improve transitions between care settings (core function of PN)
- Integrate palliative care

Care Planning & Management

- Document a care plan that contains the 13 components in the Institute of Medicine (IOM) Care Management Plan
- Perform risk stratification
- Conduct monitoring and follow-up from visits
- Estimate out of pocket cost

Patient & Caregiver Engagement

- Engage patients and caregivers in treatment plan conversations and shared decision-making
- Conduct patient education, coaching, and self-management support
- Provide patients with modes to track or share experiences
- Open medical records and documents (e.g., care plans) for patients to review and revise
- Partner with patients and caregivers to guide practice improvements

Team-Based Care

- Establish and provide organizational support for care delivery teams
- Implement collaborative team functions

Secondary Driver: Care Coordination

Provide core functions of patient navigation

- **OCM 1:** Risk-adjusted proportion of patients with all-cause **hospital admission** within the 6-month period
- **OCM 2:** Risk-adjusted proportion of patients with all-cause **ED visits** or observation stays that did not result in a hospital admission within the 6-month episode

Conduct coordinated medication management (for IV and oral therapies)

- **OCM 12:** Documentation of **Current Medications** in the Medical Record

Support referral coordination and management

- **OCM 1:** Risk-adjusted proportion of patients with all-cause **hospital admission** within the 6-month period
- **OCM 5:** Preventive Care and Screening: **Screening for Depression** and Follow-Up Plan.

Improve transitions between care settings

- **OCM 1:** Risk-adjusted proportion of patients with all-cause **hospital admission** within the 6-month period
- **OCM 2:** Risk-adjusted proportion of patients with all-cause **ED visits** or observation stays that did not result in a hospital admission within the 6-month episode
- **OCM 5:** Preventive Care and Screening: **Screening for Depression** and Follow-Up Plan.

Integrate palliative care

- **OCM 1:** Risk-adjusted proportion of patients with all-cause **hospital admission** within the 6-month period
- **OCM 2:** Risk-adjusted proportion of patients with all-cause **ED visits** or observation stays that did not result in a hospital admission within the 6-month episode
- **OCM 3:** Proportion of patients who died who were admitted to **hospice** for 3 days or more.
- **OCM 4a:** Oncology: Medical and Radiation – **Pain Intensity** Quantified.
- **OCM 4b:** Oncology: Medical and Radiation – **Plan of Care for Pain**.

Mount Sinai's Care Coordination Model

Mount Sinai's Care Coordination Model



Clinical Outcomes

- Nurse Navigators



Transitions of Care

- Oncology Coordinators



Psychosocial Support

- Lay Navigator
- Social Workers

Care Continuum


Tracking Quality Metrics Using Interactive Dashboards

Benefits of Dashboards for Data Monitoring

- ▶ Provide automated data analysis
- ▶ Provide members of the care team with a self-service tool for:
 - Data tracking
 - Real-time interventions
- ▶ Monitor outcomes tied to care coordination
- ▶ Implement quality improvement initiatives and monitor their success
- ▶ Streamline regulatory reporting

Live Dashboard Demonstration

Demo Data



Legend

Clinic Code - Click to Highlight

- Dubin
- MSDCC
- MSDUS
- MSQ
- MSW
- RTC
- Grand Total

Filters

Clinic Code - Select Site(s)

- (All)
- Dubin
- MSDCC
- MSDUS
- MSQ
- MSW
- RTC

Visit Date (OCM 4)

1/1/2018 4/17/2019

Visit Date (OCM 5)

1/2/2019 4/18/2019

Tools & Help

[Quality Measures Dictionary](#)

[Epic Documentation Tip Sheet](#)

